

North Carolina
Department of
Health and Human
Services

BLUEPRINT FOR CHANGE

Division of
Mental Health,
Developmental
Disabilities and
Substance Abuse
Services

North Carolina's plan for mental health,
developmental disabilities and
substance abuse services



State Plan 2003

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Executive Summary

Efforts to implement reform of North Carolina's public system for people with mental illness, developmental disabilities and addiction disorders began with State Plan 2001. The complete third annual issue of the Plan is available on the internet at: <http://www.dhhs.state.nc.us/mhddsas/>.

The Plan is expected to change over time as we learn more about implementing it and as we respond to recommendations from citizens throughout the state. However, the Plan's main philosophy and goals remain the same, as do its main themes:

- People with disabilities are full citizens and should have the same opportunities as other citizens to live meaningful and satisfying lives in communities of their choice.
- People with disabilities must be included in decision making and carefully listened to in order to make sure they are integrated more fully in their communities and that needed services and supports are available. Each community must support a local group, a Consumer and Family Advisory Committee, made up of only consumers and families that participates in and reviews all aspects of the public system of services/supports.
- Consumers and their families should be able to choose among service providers.
- The system must properly serve and support people at risk, minority/ethnic groups traditionally underserved and people with more than one disorder.
- The state's limited resources are to be focused on serving and supporting people with the most severe disabilities in communities rather than state facilities.
- People receiving services and supports who are not in a target population (people considered to have the most severe disabilities) will be helped to find other resources.
- Practices that show positive outcomes for people with disabilities must be continued and those that don't show positive outcomes must be stopped.
- Person-centered planning, the individual is in charge of a planning process to decide on real life outcomes he/she wants and to determine ways to achieve these outcomes, is at the heart of reform efforts.
- People in state facilities who can be supported in communities need to move to communities.
- There will be a consistent statewide process for entering and leaving public services and supports.
- There must be continuous improvement in the quality of services and supports provided.

Target Populations

Adults with Severe/Persistent or Severe Mental Illness

Recovery means that the individual gains a positive sense of self and positive outlook for the future (hope). It also includes focus on strengths, empowerment, self-determination and meaningful work and roles in life. Priority services are medication management, illness self-management, integrated

treatment/supports for dual disorders, supported employment, family education and assertive community treatment.

Children with Serious Emotional Disturbance

The focus is on helping children and adolescents “enjoy a positive quality of life; meet developmental milestones; function well at home, in school, and in their communities; and (that they) are free of disabling symptoms of psychopathology (Hoagwood et. al. 1996)”. Services/supports must be community-based and comprehensive and developed and provided within a family-centered and strengths-based orientation. Community agencies, private providers, family members and advocates are expected to work together to support local child and family teams and to hold each other accountable for outcomes.

People with Developmental Disabilities

Focus is on people who are most impacted by their disabilities. Self-determination is the philosophy and set of principles that must guide practice. Self-determination includes the freedom to develop a personal life plan; authority to control a targeted amount of money as a resource for implementing a plan; support for obtaining personal goals; responsibility for contributing to the person’s community and for using public dollars wisely.

People with or At Risk for Addiction Disorders

This group includes people at risk for addiction disorders and those found eligible for services according to the American Society of Addiction Medicine (ASAM). Focus is on recovery. Recovery involves a process of restoring or developing a positive and meaningful sense of identity apart from addiction (and other disorders) and rebuilding a life despite or within limitations imposed by the disorder(s). Again, services and supports must be person-centered, that is influenced and driven by the individual, and they must produce real life and positive outcomes.

Prevention

More and more is being learned about how to effectively prevent certain disabilities. Focusing on prevention efforts alongside treatment, services and supports is a key expectation in system reform. Teaching people how to reduce risk factors for disabilities and to improve protective factors against those disabilities is important for delaying or preventing disorders.

Local systems of treatment, services, supports

A local management entity (LME) is responsible for leading the local system. This system is partially made up of public entities, private non-profit agencies and private-for-profit firms as well as individual practitioners. This is referred to as the specialty system. It is the LMEs responsibility to make sure that there are enough available and qualified providers so that consumers and families

may choose which ones they want to work with. The system is also made up of naturally occurring community resources that provide opportunities for people with disabilities to fully enjoy community citizenship. These resources include religious, civic and social organizations as well as other public partners. The community resources taken together with the specialty system are referred to as the community system.

All participants in the community system must recognize, accommodate and respect different cultures. Participants must also provide services/supports that are controlled by people with disabilities and their families. They must pay attention to issues that affect consumer experiences with the system. Finally, providers must benefit their communities by being accountable to all citizens.

Implementing the Reform

First, clear direction and policy development were needed. Only then could details of the concepts and principles of reform be addressed and supported as well as understood by various stakeholders such as area programs, county programs, families/consumers and providers. These concepts were spelled out in SFY 02-03.

Some of the major activities this past year were:

- Area programs writing and submitting local business plans.
- Developing a plan for figuring costs in the new system (cost modeling).
- Taking an in-depth look at how consumers will enter and leave the system.
- Revising definitions of services that will be paid for. Changes must reflect models of practice as well as provider qualification and organization. This includes expectations that providers will not pick and choose who they support and serve as well as expectations that they are part of a larger community system and part of the LME provider network.
- Explaining expected provider qualifications and utilization.
- Further identification of target and non-target populations
- Implementing a new information system for paying for and reporting services (the IPRS).
- Beginning to make resources available for increasing community capacity to serve and support people with disabilities in target populations. Along with finance changes at the community level, the Division is continuing to downsize state facilities and to transfer institution-based resources to the community.
- Providing training and education about the goals of reform.

The concept of case management has been clarified. Case management is seen as a service function delivered by providers that includes assessment, planning, linking people to services/supports, coordinating and monitoring on behalf of an individual. Ultimately, case management aims to ensure that a person-centered planning process occurs for each customer and that the services/supports/treatments, formal and informal, specialty and non-specialty, are delivered/acquired according to the plan.

A key element in system reform is to ensure that individuals who fall outside of the target populations are appropriately assessed and effectively linked with alternate community resources to meet their needs. Reform efforts seek to focus limited resources on individuals with the greatest need. However, the system must not, and cannot, lose sight of the need to address transition and long term needs of individuals who will no longer be within the identified target populations.

Also in SFY 02-03, a communication bulletin process was established for communicating updates, details and other information about plan implementation. These bulletins are distributed statewide and are available on the web.

In the upcoming year, reform efforts will concentrate on phasing in the activities needed within a comprehensive public system. Many details must be established and communicated, business or clinical practices changed and rules amended. All of this must be accomplished while ensuring that activities are true to reform and to approved local business plans. Expectations will be flexible when necessary to support community transition needs.

The Division of MH/DD/SAS will maintain and publish an operations plan describing the steps being taken to implement the details of reform. This list will be posted on the DMH/DD/SA web site (<http://www.dhhs.state.nc.us/mhddsas/>) and periodically updated to include revisions and products completed.

SFY 03/04 1st Quarter (July 1, 2003 Through September 30, 2003)

- Completed cost model implementation plan for LMEs.
- Guidelines for counties on maintaining their fiscal involvement in the public system.
- Distributing a plan for supports and services, provider qualifications and rates pending federal and state approvals.
- A plan for providing supports and services to children.
- Implementing a comprehensive plan for training and education about new supports and services.
- Distributing comprehensive guidelines for provider networks.

SFY 03/04 3rd Quarter (January 1, 2004 Through March 31, 2004)

- Completing SFY 04-05 negotiated performance-based contracts between the Division and LMEs.
- Distributing a plan to address inequities in community funding.
- Implementing a long-term finance strategy.

All aspects of North Carolina's public system of mental health, developmental disabilities and substance abuse services/treatments/supports for people with disabilities are involved in the reform process. All are feeling its impact. By working together - consumers, families, citizens, advocates, local and state management entities and providers - we can achieve our long term goal of a reformed system that provides people with, or at risk of, mental illness, developmental disabilities and substance abuse problems and their families the necessary prevention, intervention, treatment, services and supports they need to live successfully in communities of their choice.

Introduction

State Plan 2003 provides an overview of the continued developments in the North Carolina mental health, developmental disabilities and substance abuse system reform efforts. This is the third annual issue of the State Plan and reflects a great deal of work that has been accomplished to date as well as key developments that will occur in the upcoming state fiscal year.

This version of the State Plan is organized into the following six major chapters:

Chapter 1: Foundation of Reform – This chapter addresses the question “*Why are we reforming the system?*” This includes an overview of public policy considerations and challenges as well as recent national and state policy developments. Building from these policy and historical perspectives is the foundation of our reform efforts – our mission, guiding principles and vision – that addresses the question “*Where are we going?*”

Chapter 2: The Citizens We Support and Serve – This chapter addresses the question “*Who are we to support and serve?*” This chapter includes a description of each of the populations that are to be served by the system with particular attention to people and groups who have been or are at risk of being inadequately supported and served. The term “citizen” is used in this document as a description of all residents of our state.

Chapter 3: Supporting and Serving Our Citizens -- This chapter addresses the question “*What are the supports and services to be provided?*” This chapter presents an overview of supports and services that are considered best practice in relationship to the people the system is to support and serve. This includes a description of the foundation of supporting and serving people – person-centered planning.

Chapter 4: Local Systems Supporting and Serving Our Citizens and Communities – This chapter addresses the question “*How are we to locally carry out the supports and services?*” This chapter provides a description of the key characteristics of the community system, the formal role of the consumer and family advisory committees (CFACs), the responsibilities and functions of the public local management entities (LMEs) and the nature and organization of the support and service provider network.

Chapter 5: State System Supporting and Serving our Citizens and Communities-- This chapter addresses the question “*What is the state's role in supporting the efforts of reform?*” In this chapter a brief overview of the state consumer and family advisory committee (S-CFAC) and the responsibilities and functions of the re-organized Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) is provided.

Chapter 6: Operationalizing the Plan—This chapter addresses the challenges of managing change and presents an overview of developments to date as well as a broad presentation of developments that will occur during state fiscal year 03/04. This is intended to allow us both an

opportunity to acknowledge the success we have had as well as establishing an understanding of the key planned efforts that we will embark upon in the upcoming year.

Chapter 1: Foundation of Reform

Overview

State Plan 2001: Blueprint for Change initiated the first major reform of North Carolina's mental health, developmental disabilities and substance abuse (mh/dd/sa) services system in more than thirty years. The State Plan was developed in response to the passage of Session Law 2001-437 that called for sweeping reforms in the service system over a five-year period. Carmen Hooker Odom, secretary of the North Carolina Department of Health and Human Services, initiated the State Plan to return North Carolina to its once proud level of distinction, one that includes a system of innovative and appropriate supports and services that comply with federal and state rules and expectations. This is the second annual revision.

The main concepts contained in the State Plan's original version are unchanged. Focusing the state's limited resources on those individuals who have the most severe disabilities continues as the central theme. This revision incorporates recommendations received from system stakeholders over the past two years, provides additional detail in particular areas and clarifications regarding issues that have been raised. In principle, the State Plan is a strategic process, with developments reflecting the acquisition of new knowledge and understanding.

Most people are aware of the reasons for the system reform movement in North Carolina. They agree that reform, though difficult, is necessary in order to reclaim the exemplary heritage that once characterized North Carolina's services to people with disabilities. There is some distance, however, between knowing that change must occur and moving forward to bring about reform. There may be as many perspectives and viewpoints on what the mh/dd/sa system should look like as there are people who have interest in the system. Coming together, then, becomes an important focus and challenge in finding the right road and in making the journey.

This chapter includes a review of the recent major developments in legal and social policy that indicate direction for reform. Evaluating growing trends in policy may also provide valuable hints about potential pitfalls to avoid. As public policy evolves over time, it creates the framework on which service systems are built and establishes the community context of daily life for people with disabilities. Key policy changes over recent decades, together with advances in treatment, services and supports, are reshaping the profile and design of contemporary public systems.

Changing Times

The lives of people with severe types of mental illness, emotional disturbances, developmental disabilities and substance abuse disorders have been greatly influenced by public policy. These policy developments revolve around issues such as reconciling concerns with social justice and economic efficiency, challenges present in supporting people with disabilities as full citizens and the changing perspective on relationships necessary for sustaining a quality life. Most recent

developments at the national level and within the state of North Carolina serve to provide us with direction needed to embrace and celebrate this road that we are traveling.

Public Policy and Systems Direction

Several key issues have been at the center of the policy debates and program/service developments over recent decades. Our general struggle as a democratic society has revolved around efforts to reconcile social justice and economic concerns. Although this struggle occurs in tandem with every public policy effort, each has enjoyed a particular dominance.

Social justice was a dominant force from the mid-1950s through 1980. All three branches of the federal government worked in concert to form a new value/attitude toward people with disabilities. The civil rights and anti-poverty efforts of Congress resulted in statutes recognizing citizens suffering discrimination as well as creating financing programs for the poor such as Medicaid. The Community Mental Health Facilities Construction Act created opportunities for states to move toward community-based systems of care and programs. Simultaneously, the judicial branch strongly influenced community-based development in landmark cases citing poor conditions in many large institutional settings. Future protections from such conditions were advanced through efforts such as passage of the Civil Rights of Institutionalized Persons Act (CRIPA).

This time period also saw the advancement of due process protections against arbitrary denial of entitlements (*Goldberg vs. Kelly*) and increased demands for public systems to operate in the light of day (specifically, Administrative Procedures Act, Freedom of Information Act and Open Meetings Act).

Focus of the social justice era was to protect the civil rights of each individual and to establish the societal equality of people with disabilities. Two major criticisms of the time centered around whether these policies were actually working as they were intended and how to manage the spiraling expenditures of these policy efforts when public revenue strategies were in question.

These concerns ushered in a policy shift in the 1980's to deal with issues of economic efficiency – policy management and accountability. Direct fiscal changes began to occur in tax policy, revenue sharing and indexing (virtually automatic cost increases for programs), as well as indirect changes such as increasing deregulation and alternative methods to organize public policy.

Comparisons between publicly operated systems and those that are wholly privatized have shown that each has its relative merits and benefits, but neither model, taken alone, produces satisfactory results. Therefore, continuing developments in policy have focused on the best mix. These approaches clearly identify that, for the populations we serve, public entities at the state and local levels are designed to ensure public accountability, while community organizations are designed to ensure provision of services.

The concepts of social justice and economic efficiency are often posed as polar opposites. However, advancements in the disability movement would suggest that they could actually work

together. Initial responses to the adverse treatment of people with disabilities created the disability rights movement. Most of these efforts resulted in protections for what some may define as special people. However, over the past ten to twenty years we have experienced a transformation from the disability rights era to an era of full citizenship. The collective efforts of those concerned with social justice have resulted in the enactment of statutes (i.e., Americans with Disabilities Act, Individuals with Disabilities Education Act, revisions to the Rehabilitation Act, the Fair Housing Act) and court decisions (i.e., Olmstead) that have a common theme – people with disabilities are full citizens and should be afforded opportunities like all citizens.

Public Policy and Key Challenges

Much of the underlying basis for policy shifts over the last forty or fifty years stems from legal and ethical concerns about the proper role of government in the personal lives of private citizens. With regard to adults with mental illness, for example, a key policy issue has focused on deprivation of rights to due process and of personal liberty. It is a loss of freedom to impose restrictions or control on a person if that person does not have an opportunity to dispute what is being done. These fundamental freedom concerns have led to reforms in civil commitment requirements (due process considerations) and alternatives to more restrictive treatments and settings. The continued debate grapples with the relative balance between the inherent freedoms afforded each individual citizen and the restrictions or controls imposed on individuals who have mental health conditions that may inhibit their judgement in a manner that would unintentionally bring harm to themselves and/or others.

Civil liberty concerns are also the focal point of continued policy debates regarding adults with developmental disabilities; however, these issues are primarily targeted toward a desire to protect these individuals from harm. Evolving policy in this area has been strongly influenced by innovative community-based, support-oriented models of practice. As the community's ability to support and accommodate these individuals advances, the boundaries of reasonable risk expand and people with developmental disabilities are afforded new opportunities for natural community life.

As minors, children with severe emotional disturbances have limited rights and voice. Policy developments have been greatly influenced by a best interest perspective, that is, whatever is in the best interest of the child. Most recently, the best interest debate has been shaped largely by concerns regarding stabilization of life domains (family, school and friends). A child has limited and fragile life domains. Policy efforts have focused on developing a range of flexible supports that are best delivered within the life environment of the child, including adequate safeguards and alternatives where health and safety issues are a valid concern. Additionally, policy has encouraged systems collaboration as a means to create a seamless and more responsive mechanism to address child and family needs.

Sometimes, solutions to troubling policy questions begin with grassroots efforts to help oneself and others. The modern view of alcoholism arose in response to the traditional view of the alcoholic as a person of poor moral character whose treatment was relegated to city drunk tanks, wards of public hospitals or the back wards of aging and deteriorating state psychiatric hospitals. Sometimes alcoholics were sent to local jails. The birth of modern substance abuse treatment began with the creation of Alcoholics Anonymous (AA) by Bill W. and Dr. Bob in 1935. This movement was based on the premise that a recovering alcoholic could assist in the recovery of

another alcoholic through personal fellowship, support and sponsorship. This early beginning evolved into a treatment movement in the 1970's and 1980's that established a national network of professional addiction treatment services.

Research has shown that alcohol and drug abuse treatment is both clinically effective and cost effective in reducing drug consumption and also for the associated health and social consequences that characterize addiction. Treatment gains are typically found in reduced intravenous and other drug use, reduced criminality and enhanced health and productivity. Yet today, at the cultural and social policy level, there is growing evidence that, despite the proven success of treatment services, alcoholism and other addictions are being de-medicalized, re-stigmatized and re-criminalized. Care and treatment of alcoholics and addicts is once again shifting toward punishment and control in the criminal justice system. Recovering people constitute one of the largest and most invisible communities in America, and they are beginning to reassert themselves as a teaching and healing force.

Public Policy and a View of People

Policies toward people with disabilities establish the context in which they live. Over recent decades there has been a shift – moving from dependency to the notion of independence and, finally, to inter-dependence.

The dependency perspective stems from a long-held belief that the lives of people with disabilities were best placed in the hands of others who would make decisions for them for their own protection. At the height of the institutional era, more than 500,000 people were living involuntarily in these constantly impoverished institutions, dependent on government for every meal and article of clothing.

The independence perspective grew out of the civil rights movement. Renewed debate about the nature and causes of mental illness coupled with strong denunciation of long-term detention for people who had committed no crime, forced a wrenching shift in policy that had far-reaching, serious consequences. Thousands of people streamed out of state hospitals. Federal funding was available to build local clinics and to provide personal income that was intended to support community-based treatment. But several things happened that resulted in negative impact: 1) many people exercised their new found independence and failed or refused to get the help available, 2) over time funding for these programs slowly dissipated, and 3) perhaps most important, at that time the system did not know how to effectively support people with disabilities in communities.

The unsatisfactory outcomes of the independence era led to a new examination of meaningful community life. Observers began to focus on the interconnected nature of supports, services and treatment. This includes reciprocal relationships with other people, places and things and the natural human tendency to acquire resources within the interconnected world that make life safe, meaningful and satisfying. This realization paved the way to a whole new universe of possible methods and technologies that recognize and help people acquire the life supports required for living a full and rich life of choices and opportunities.

After a very rough start, the evolution of public policy over recent years coupled with advancements in knowledge, treatment, services and supports, now make it possible to develop a service system for people with disabilities that both acknowledges and honors their right to live in natural communities of their choice.

United States Reform History: 1990 – Present

During the late 1990's and early 2000's, the federal government began to place more emphasis on the quality of the nation's mental health and on mental health reform. In 1999, the first *Report of the Surgeon General on Mental Health* was released. On the 12th anniversary of the Americans with Disabilities Act, February 1, 2001, a program to promote the full participation of people with disabilities in all areas of society – the New Freedom Initiative – was announced.

The *Report of the Surgeon General on Mental Health* was the result of collaboration between the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institutes of Health (NIH). This collaboration and the report recognize the relationship between mental health and physical health and emphasize that mental health and mental illnesses are important concerns at all ages. The report provides a review of scientific advances in the study of mental health, indicating that mental health and physical health are inseparable. Further, “mental health” and “mental illness” are not opposite but may be considered as points on a continuum. This new research points the way toward intensifying interest and concerns about disease prevention and health promotion. Scientific literature summarized in the report also shows that a variety of effective treatments exist for various mental and behavioral disorders that may occur across a person's life span.

The report also describes how people with mental illness are stigmatized and the disparities in the availability of and access to services in comparison to other areas of health. These disparities are often connected to a person's financial status, either through inadequate mental health insurance benefits or from the lack of any health insurance. The report's premise is that negative stereotyping will dissipate when people understand mental illnesses as legitimate illnesses that are responsive to treatment.

The report makes a number of recommendations related to mental health:

- Continue to build the science base.
- Overcome stigma.
- Improve public awareness of effective treatment.
- Ensure the supply of mental health services and providers.
- Ensure delivery of state-of-the-art treatments.
- Tailor treatment to age, gender, race and culture.
- Facilitate entry into treatment.
- Reduce financial barriers to treatment.

Recognizing that there are continuing persistent obstacles for people with disabilities to realize full participation in American society, the federal New Freedom Initiative is composed of the following key components, subject to full funding by Congress:

- **Increasing access to assistive and universally designed technologies:** federal investment in assistive technology research and development and in access to assistive technology.
- **Expanding educational opportunities for Americans with disabilities:** increasing funding for the Individuals with Disabilities Education Act (IDEA) and focusing on reading in the early grades.
- **Integrating individuals with disabilities into the workforce:** expanding telecommuting, implementation of “Ticket to Work” that allows individuals with disabilities to choose their own support services and maintain health benefits when working, full enforcement of the Americans with Disabilities Act and innovative transportation planning.
- **Promoting full access to community life:** promoting home ownership through use of up to a year’s Section 8 housing vouchers for down payment on a house; supporting the most integrated community-based settings for individuals with disabilities in accordance with the Olmstead Supreme Court decision; and increasing the accessibility of organizations that are currently exempt from Title III of the ADA (such as churches, mosques, synagogues and civic organizations).

The recent interest by the federal government in mental health issues and in promoting full participation by people with disabilities in the fabric of community life supports the movement for mental health reform in North Carolina.

The Center for Substance Abuse Treatment (CSAT) began the National Treatment Plan Initiative in the fall of 1998, to provide an opportunity to reach a national consensus on how best to improve substance abuse treatment. The National Treatment Plan Initiative envisions a society in which people with a history of alcohol or drug problems, people in recovery and people at risk for these problems are valued and treated with dignity and where stigma, accompanying attitudes, discrimination and other barriers to recovery are eliminated. It envisions a society in which substance abuse and dependence are recognized as a public health issue, a treatable illness for which individuals deserve treatment. It envisions a society in which high-quality services for alcohol and drug problems are widely available and where treatment is recognized as a specialized field of expertise.

*Changing the Conversation: That National Treatment Plan Initiative to Improve Substance Abuse Treatment*¹ presents a set of guidelines and recommendations drawn from the work of expert panels and the many individuals across the nation that participated in public hearings and submitted comments.

¹ Published by U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, November 2000. See www.samhsa.gov.

Advances made in developmental disabilities have centered on promoting the principles self-determination. The Community Supported Living Arrangements (CSLA) Medicaid pilot efforts of the early 1990s and the Robert Wood Johnson self-determination demonstration projects of the 1990s both led to the development of the Medicaid Independence Waiver. Public policy direction continues to build on the principles of command and control of one's life.

North Carolina Reform History: 1990 – Present

North Carolina has benefited from a history of mental health pioneers who have courageously built the mental health system we enjoy today. These people developed a much-needed focus on clients and service delivery in the communities. Their years of courageous development and advocacy cannot be dismissed.

Dorothea Dix played a large role in developing North Carolina's framework of mental institutions. When Miss Dix came to North Carolina, she discovered more than 1,000 mentally ill people housed in jails, poorhouses and private homes. She made her discovery known across the state, and eventually presented it as a "memorial" to the legislature. Her document was very compelling and emphasized that the insane should be removed from jails for the benefit of themselves and the other inmates. She pointed out the economics other states had realized through moderate employment and moderate exercise and gave details about needed buildings and equipment.

The asylum movement and community-care movement that followed were great accomplishments; yet neither was perfect. For example, the asylum movement often warehoused patients neglectfully. And, de-institutionalization of mental patients often led to abandonment on the streets or forced care by ill-prepared families and communities. Years later, some patients found themselves placed in the very jails that Dorothea Dix had deplored and emptied 100 years earlier.

Mental health reform began in earnest during the 1990s. North Carolina, like other states began an initiative to maximize federal dollars. Rapid growth in Medicaid funded services and revenues caused attention to the system. As a result of the attention, inadequacies in the administrative systems of local mh/dd/sa programs were uncovered. Due to the rapid growth, area programs had not been able to build the infrastructure quick enough to handle the Medicaid requirements. As a result, billing became problematic and intense state oversight was enacted. In addition to problems with Medicaid, in 1995 a multi-county area program went bankrupt without prior awareness of local county commissioners, although the state was aware of the situation. In 1997, another similar incident occurred when the county commissioners of a single county area mental health program had to spend \$400,000 per month to keep it operational. County commissioners also began to receive increased complaints from consumers regarding local services and lack of county input. As a result the North Carolina Association of County Commissioners created a mental health task force that resulted in a recommendation to promote legislative changes in the mental health system.

At the same time that county commissioners were hearing local complaints, the Charlotte Observer ran a series of articles about problems in the mental health system, including 34 deaths at state facilities. Due to a severe nursing shortage and record keeping citations at Dorothea Dix Hospital, the federal government threatened to withhold funding. Vast differences of services and funding

existed across the state. Clearly, the lack of best practices in mental health services pointed to the need for reform.

Also during the 1990's juvenile justice reform made counties aware of the lack of system integration. State lawsuits called Thomas S and Willie M were requiring massive financial obligations by the state. The need for community services was emphasized through the Olmstead Act. Other federal changes were also occurring. The federal Medicaid agency said that states must give consumers more choice in the selection of providers. In the meantime, two additional area programs had to be dissolved for lack of funding and others experienced financial difficulties. Providers charged that area programs restricted access to public clients and public funds. Trust had eroded among all stakeholders, including the Division, area programs, providers, consumers and state facilities. Public awareness was very high regarding the problems with in the mental health system at both the state and local level. Serious changes needed to happen.

The North Carolina General Assembly contracted for a series of studies and audits of the mh/dd/sa system of services between 1995 and 1999. A state audit revealed that oversight of local programs was too removed from the both the local government structures and the state. The summary of the various studies had similar recommendations:

- Increase community capacity.
- Decrease reliance on state-operated facility services.
- Establish credible state oversight.
- Establish local accountability to local and state government.
- Examine governance options for area programs.
- Establish funding mechanisms for expanding community capacity including “bridge” funding.
- Establish consistency and standardization of services and finances across the state and among disability groups, where appropriate, for the operations of the mh/dd/sa system.

In July 2000, House Bill 1519 created the Legislative Oversight Committee (LOC) for MH/DD/SAS to develop a plan to reform the state system. Mental health reform legislation (HB 381- Session Law 2001-437) was passed in 2001. Key components of this legislation include:

- (1) Consumer focused.
- (2) Increased accountability to counties.
- (3) Improved business practices at both the state and local level.
- (4) The establishment of four governance options for the local mh/dd/sa system.
- (5) The development of the local business plans through an inclusive community process that ultimately required approval by the County Commissioners.

Consumer-focused means that the system is expected to be person centered and driven – consumers get what they need, when they need it and where they are. Focus is on community-based services, supports and treatments that are outcome driven. Improved business practices means paying local programs to manage local networks of services and holding the programs accountable for achieving agreed upon outcomes. The legislation also sets a goal that each local

program must have a minimum population base of 200,000 or at least five counties to ensure scale and scope economy. Increased accountability includes a greater participation by county officials in the oversight of the local system.

State Plan 2001: Blueprint for Change was delivered to the LOC in December 2001 stating how the Department would implement reform. The first local decision required each county to select a form of governance. In October 2002 counties notified the Department which of the four governance options they had chosen. In 2003, local business plans were received from counties. Phase I local management entities (LMEs) begin operation July 2003, with Phase II and III LMEs to be certified by January 2004 and July 2004. LMEs have three years to fully implement approved local business plans.

North Carolina leaders, along with the many professional mental health associations and advocacy groups, understand the state's specialty system (mental health, developmental disabilities and substance abuse services) is once again at a crossroads. While a primary focus is still toward the people supported and served by the system, the state faces major problems due to dramatic changes in the economics of health care delivery and the unique evolutionary history of North Carolina's system of the specialty system. The massive disconnect between the resources needed for supports and services and the resources available to provide the supports and services is the most important factor facing North Carolina.

Most states face the same challenges that North Carolina does – dealing with the changes in Medicaid and Medicare. Indeed, most states are in a time of uncertainty and turmoil in the delivery of specialty supports and services. And, in many states, the changes have created disastrous results – disrupting the care of hundreds of thousands of vulnerable people. Fortunately, North Carolina has an opportunity to learn from these past experiences, avoid such disruptions and greatly improve its own system.

Mission, Principles, Vision

The mission, principles and vision of the State Plan guide and inform North Carolina's reform effort through the great changes ahead and tell us when we have achieved success. The road may be long, the journey will be hard, but the destination is in sight.

Mission

North Carolina will provide people with, or at risk of, mental illness, developmental disabilities and substance abuse problems and their families the necessary prevention, intervention, treatment, services and supports they need to live successfully in communities of their choice.

Guiding Principles

- Treatment, services and supports to individuals and their families shall be appropriate to needs, accessible and timely, consumer-driven, outcome oriented, culturally and age appropriate, built on individual strengths, cost effective and reflect best practices.
- Research, education and prevention programs lower the prevalence of mental illness, developmental disabilities and substance abuse; reduce the impact or stigma; and lead to earlier intervention and improved treatment.
- Services should be provided in the most integrated community setting suitable to the needs and preferences of the individual and planned in partnership with the individual and/or family.
- Individuals should receive the services needed based on a person-centered plan and in consideration of any legal restrictions, varying levels of disability, and fair and equitable distribution of system resources.
- System professionals will work with individuals and their families to help them get the most from services.
- Services shall meet measurable standards of safety, quality and clinical effectiveness at all levels of the mental health, developmental disabilities and substance abuse system and shall demonstrate a dedication to excellence through adoption of a program for continuous quality improvement.
- All components of the mental health, developmental disability and substance abuse system shall operate efficiently.

Vision

- Public and social policy toward people with disabilities will be respectful, fair and recognize the need to assist all that need help.
- The state's service system for persons with mental illness, developmental disabilities and substance abuse problems will have adequate, stable funding.
- System elements will be seamless: consumers, families, policymakers, advocates and qualified providers will unite in a common approach that emphasizes support, education/training, rehabilitation and recovery.
- All human services agencies that serve people with mental health, developmental disabilities and/or substance abuse problems will work together to enable consumers to live successfully in their communities.

Consumers will have:

- Meaningful input into the design and planning of the service system.
- Information about services, how to access them and how to voice complaints.
- Opportunities for employment in the system.
- Easy, immediate access to appropriate services.

- Educational, employment or vocational experiences that encourage individual growth, personal responsibility and enjoyment of life.
- Safe and humane living conditions in communities of their choice.
- Reduced involvement with the justice system.
- Services that prevent and resolve crises.
- Opportunities to participate in community life, to pursue relationship with others and to make choices that enhance their productivity, well being and quality of life.
- Satisfaction with the quality and quantity of services.
- Access to an orderly, fair and timely system of arbitration and resolution.

Providers and managers will have:

- Opportunity to participate in the development of a state system that clearly identifies target groups, core functions and essential service components.
- Access to an orderly, fair and timely system of arbitration and resolution.
- Documentation and reimbursement systems that are clear, that accurately estimate costs associated with services and outcomes provided and that contain only those elements necessary to substantiate specific outcomes required.
- Training in services that are proven.

Managing the Challenges of Change

Since the original release of *State Plan 2001: Blueprint for Change*, the state and local communities have identified some challenges and obstacles that need to be addressed and overcome in order to take the next steps in this evolving process. It is necessary to adopt some overarching goals that guide the process to keep us on track toward the system envisioned in the State Plan.² The goals and direction provided in the *State Plan 2001: Blue Print for Change* as well as the *State Plan 2002* update remain relevant.

Investing for Success

There is an initial challenge for state and local systems in determining how best to manage finite resources to respond to what seems to be infinite need. To begin, we need to look very closely at whom we support and serve, as well as the manner in which we support and serve them. Consistent with the principle that government assistance is limited to those who are most in need, the target populations in the reformed system are those people with the most severe disabilities.

² The goals listed here are from *Changing the Conversation*, US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, November 2000.

Managing Finite Resources

We are required to apply the best and emerging best practices that have resulted in positive outcomes for people. Services that fail to render real life outcomes for people need to be discontinued. Second, there should be appropriate transition plans for people with disabilities who can be served in their communities but are currently in state facilities. These people should live and receive services/supports in their communities. There is also a valid concern that some people with lower levels of need will require services from elsewhere in the community. Part of the community planning process involves looking to the community – including faith-based organizations and grassroots agencies to develop responses for all citizens in need.

No Wrong Door

There must be many avenues of access where people can enter the system and that address the need for a customer-service oriented approach with a genuine desire to help those who enter. The concept of uniform portal, described later in this document, establishes the expectation of a consistent statewide process for entering and leaving the public service system that supports and facilitates access to services no matter where the person enters.

Commit to Quality

We need to take up the challenge of continuous quality improvement. We make the best use of information available to us to help appraise our performance, measure outcomes and look constantly for opportunities to do things better. If this means breaking with a tradition that honest evaluation tells us is not effective, then we must abandon that tradition and find something that does work.

Change Attitudes

Across the board, we need to work on issues of community inclusion and capacity development for people with disabilities recognizing and honoring their right to full citizenship in communities of their choice. It means that we listen carefully to the experiences and observations of the people we serve; they have a view of the system that most of us never see. For some of us, it means loosening our grip on a present that is now the past and reaching out to embrace the promise of the future.

Building Partnerships

An important focus of this plan is the creation of opportunities for people with disabilities and their families to participate in problem solutions. People in treatment, services and recovery are the most eloquent communicators about the value of services in their own lives. We are required to recognize the unique strengths and talents that are already present throughout the system and to gather them into an integrated, synergistic whole in which each contributes its best, and the total

has greater value than the sum of any of its parts. Another essential element is to build partnerships between and among the various systems with overlapping responsibility for individuals who may have disabilities and their families. These partnerships can help all systems to fulfill their responsibilities more effectively, while assuring the best use of resources.

Chapter 2: The Citizens We Support and Serve

Providing services to individuals with the most severe disabilities is the primary focus of the re-designed system. As legislatively directed, the Department established appropriate criteria to identify individuals with various disabilities. The criteria included not only diagnostic³ and functional elements but also circumstances unique to each individual such as availability and access to appropriate services that meet the needs of each person. Criteria regarding the urgency and intensity of needs will be applied throughout the system to establish a structured process for prioritizing services and/or managing waiting lists.

The population described in this chapter-- the "target population"-- represents individuals with the most severe types of disabilities. The publicly sponsored mental health, developmental disabilities and substance abuse specialty system is the response arrangement for these individuals. However, there are several additional considerations to be made, as follows:

- Regardless if an individual is part of the target population, potentially, any citizen could seek services through the public system. The system's response to such requests could include screening, triage and referral, as key examples. For individuals not in the target population who have the personal resources (insurance and ability to pay), the system's response could also include linking those persons to private non-publicly sponsored providers for longer term services-- post crisis individual therapy, as an example.
- Medicaid beneficiaries who have a condition that meets medical necessity for particular covered benefits are entitled to said benefits. These individuals are entitled to receive the supports, services, treatment and/or care regardless of whether they are identified as part of the state defined target populations. Medicaid beneficiaries who are not part of the state defined target populations, typically, require individual practitioner types of services that are less intensive and shorter term in duration. Medicaid beneficiaries who are included in the state defined target populations, generally, require supports, services, treatment and/or care that are more comprehensive, intensive and of longer duration. The best practices described in Chapter 3 are intended for these individuals and the system described in Chapter 4 are designed for these individuals.
- Individuals who are part of the state defined target populations who are not Medicaid beneficiaries are intended to be responded to by the publicly sponsored specialty system described in Chapter 4. However, the provision of services to these individuals is not an entitlement as in the case of Medicaid beneficiaries. Thus, the publicly sponsored specialty system is challenged with managing its available resources to meet the needs of these priority populations.

³ Clinical diagnoses are made according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM IV-R). Classification for billing purposes is made according to the International Classification of Diseases (ICD-9).

Chapter 6 describes an extension of the transition period for the non-target populations. There are several factors that have led to this decision, as follows:

- **The need to better understand and establish the expectations regarding target population penetration rates.** This involves determining the number of people within the target populations that would be expected to be present in a community and the percentage of these people the system should be serving. Included among those would be individuals currently residing in state-operated institutions, out-of-state placements and out-of-county placements, virtually all of whom are part of the target populations. The process would also include identifying and ensuring access to individuals residing in the community who are part of the target population and who are not being served, are underserved or require different services.
- **The need to provide more time for the system itself to transition. There is variation around the state in terms of the numbers of target populations and non-target populations being served.** Community systems have been instructed to move to the target population while finding and/or sparking the development of other community resources to respond to the needs of the non-target populations (State Plan Communication Bulletin #003-- "Management of State Plan Target and Non-Target Populations"). This should continue, however we do not desire to simply extinguish needed services for these individuals. We are also continuing to learn of the need for some flexibility in the system for providing publicly sponsored services for these individuals – a "basic benefit" package. This "basic benefit" package will be less than the "enhanced benefit" available under the comprehensive specialty system but would be beyond the "core services" that are potentially available for all citizens.
- **The need throughout this continued process of transition of assuring the dedication of our limited resources to individuals in the target populations-- those with the most severe disabilities.** As reform public policy, this focus remains unchanged. The system can't opt to serve individuals with less severe needs while not sufficiently identifying and responding to the needs of the target population. Although there are limited alternatives for individuals who are not part of the target population, there are no other alternatives for individuals who are part of the target population.

Embracing Diversity

Across and within each of the disability groups – adult mental health, child mental health, developmental disabilities and substance abuse – particular attention is needed to embrace people who are at risk and/or have been traditionally underserved.

Nationally and in North Carolina, cultural and linguistic diversity is a growing challenge for health care delivery systems. During the last decade the number of people in need of health care services who have limited English proficiency has risen dramatically. For example, between 1990 and 2000, the Spanish speaking Latino population in North Carolina grew by almost 400%, giving North Carolina the fastest growing Latino population in the country. According to the 2000 United States

census, approximately half of North Carolina Latinos have limited English proficiency or are unable to speak English well. Such language barriers can impair a Latino's ability to access needed programs and services, and many are not knowledgeable about how the US health care system works.

Minority and ethnic groups are disproportionately represented within our present mh/dd/sa system. For example, according to the *Client Statistical Profile* for 2001-2002, African-Americans, who comprise 21.6 percent of North Carolina's population, made up 34 percent of persons served.⁴ The Hispanic/Latino population represents approximately 5 percent of our state's population, yet are 1.74 percent of active service recipients.⁵ There may be many reasons for variations in minority representation. These may include cultural and socioeconomic issues as well as concerns about stigma or negative attitudes toward people with disabilities.

Adults who are 65 or older have been shown to be at greater risk, are under identified and under served by the MH/DD/SA service delivery system, and they are an increasing component of North Carolina's population. The number of seniors in North Carolina has continued to grow rapidly in the last decade reflecting an increase in the general population and greater longevity. In North Carolina in 2000 there were 969,048 adults age 65 or older. This is 12 percent of the state's residents. These numbers are expected to rise rapidly as "baby boomers" approach retirement. By 2020, the population 65 and older will have grown 71 percent from the 2002 baseline compared to 36% for the general population. North Carolina's population over age 65 has a lower life expectancy, higher rates of poverty and lower average education and income than their national counterparts.

While many seniors are healthy, engaged and living in comfortable circumstances, others face declining health, poverty and social isolation. In 2000, 30.8 percent of people age 65 or older in the community reported some level of physical disability and 12.6 percent reported a mental disability. Forty seven percent of people age 85 or older have Alzheimer's disease. The Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Department of Health and Human Services, has noted that older adults often do not recognize the need for or availability of treatment. This results in a gross under utilization of mental health services.

Prevalence of mental health problems among adults 65 or older is as follows: 11.4 percent suffer with anxiety; 6.4 percent have cognitive impairments and 4.4 percent with depression and other mood disorders (SAMHSA 2002). Estimated prevalence for heavy alcohol use varies between 3 and 25 percent (SAMHSA 1998). Alcohol use can be a special problem for those over 65 who are often heavy users of prescription medicines and over-the-counter drugs. This use of prescription medications and over-the-counter drugs places these individuals at increased risk for misuse and adverse drug reactions. Older white men have a six times greater risk for suicide than the general population. It is also estimated that only half of older adults who acknowledge mental health

⁴ African-Americans served represent 6 percent of the total African-American population in North Carolina.

⁵ Hispanic/Latinos served represent 1.4 percent of the total Hispanic/Latino population in North Carolina.

problems receive treatment from any health care provider. The growth of the older population with developmental disabilities is also of major concern. These adults are increasingly outliving their parents and are at risk for losing their primary support. In North Carolina estimates for adults age 60 and over with developmental disabilities range from 5,400 to 13,000. Special attention will need to be given to securing the services and supports necessary to help these older adults remain in the community.

North Carolina's senior population is not a homogenous group but differs in race, ethnicity, gender, marital status and rurality, all of which are factors that affect their risk for mental health, developmental disabilities and substance abuse problems.

The prevalence rates for persons who are culturally deaf, that is, users of American Sign Language (ASL), are estimated at 0.49% of the general population (National Center for Health Statistics). Based on the 2000 Census, sign language users in North Carolina total approximately 37,500.

Culturally competent and language accessible systems demonstrate the capacity to communicate effectively with persons who are deaf or hard-of-hearing and persons with limited English ability and/or low literacy skills. Such organizations have policies, structures, practices, procedures and dedicated resources to support this capacity.

Significant barriers exist to the delivery of linguistically competent health care services. These include but are not limited to the following:

- Health care providers are not typically trained in cross-cultural approaches, which include working with interpreters as necessary to provide language accessible services.
- There are shortages in resources and qualified personnel to provide medical translation and interpretation services especially in rural areas.
- Segments of the immigrant and refugee population are unlikely to advocate for translation and interpretation services due to linguistic and cultural barriers, which include the perception of adverse political repercussions.

Accurate and honest communication between health care providers and consumers is essential to the effective delivery of quality health care services. Culturally competent and language accessible systems attempt to utilize bilingual professionals and paraprofessionals where available. Providing interpretation and translation services is another key strategy given the current population profiles and projected trends.

Strategies that local systems can use in addressing cultural and linguistic disparities include:

- Publishing written materials in languages reflective of the local population.
- Collaborating with the Minority Health Advisory Council on addressing barriers to services in local systems.
- Developing cultural competency.

- Using bi-lingual services as a paid skill.
- Making special efforts to recruit and hire qualified workers from different ethnic/racial groups.

While men and women with disabilities share many common experiences related to their conditions, systems need to recognize the fundamental differences as well. These differences are reflected in patterns of service utilization and in the life experiences of the individual. To meaningfully acknowledge these differences will require a shift away from gender-neutral service and system planning and a focus on unique needs. Systems better serve women when:

- Services are planned and evaluated with the involvement of women consumers and allied women's agencies.
- Services are provided with a holistic family-centered approach that includes services provided to children.
- Services and planning recognize consumer diversity in terms of ethno-cultural ancestry, heritage, age and sexual orientation.
- Impact of trauma/violence is acknowledged and addressed.
- Services sensitively and respectfully address issues related to sexuality, pregnancy and parenting.
- The benefits of woman-centered services are recognized, including housing and therapeutic settings in which a woman's privacy, security and social support needs are considered.
- The distinctive ways in which women experience dual conditions of mental illness, developmental disabilities and/or substance abuse are understood.
- Appropriate primary medical care is accessible for all aspects of physical health.

Part of the local planning process leading to local business plans was to include a thorough examination of the socioeconomic and ethnic/racial composition of each region and creation of strategies for meeting these special needs. Issues related to access to services and disparities in consumer outcomes by race/ethnicity, gender, sexual orientation, age, disability, geographical location, income and education level will be tracked as part of the outcomes system and will be included in report cards, published reports on outcomes.

Co-occurring Disorders

Individuals who meet the criteria for a target population often have more than one disability. People with severe and persistent mental illness (SPMI) or youth with severe emotional disturbance (SED) may also have a developmental disability, mental retardation and/or a substance abuse problem. Such a pattern can occur among all disabilities in any combination, although the co-occurring disorder(s), taken alone, may not reach the level of a target population in the second category(ies).

Generally, systems have done a poor job of recognizing and responding to these situations. Many organizations tend to focus their attention on specialized responses to a single disability – adult

mental health, child mental health, developmental disability or substance abuse – and fail to recognize and address accompanying problems. Sometimes public funding mechanisms and budgetary rules get in the way of appropriately addressing all of an individual's needs.

The State Plan for system reform adopts a cross-disability approach that requires response to all of the conditions that affect successful community living. Clinicians must be able to assess for co-occurring disorders, and treatment, and services and supports need to be integrated across all disabilities.

Adult Mental Health

According to estimates by the federal Center for Mental Health Services, during a 12-month period, approximately 5.4 percent of the adult population have a serious mental illness. This means that in North Carolina, during a 12-month period, approximately 322,000 adults have a diagnosable mental, emotional or behavioral disorder that has resulted in functional impairment that substantially interferes with or limits one or more major life activity. Within this population, approximately 99,000 have severe and persistent mental illnesses (SPMI) that interfere substantially with their ability to manage the demands of daily living.

Mental illnesses are disorders characterized by disturbances in a person's thoughts, emotions or behavior. The term "mental illness" can refer to a wide variety of disorders, ranging from those that cause mild distress to those that severely impair a person's ability to function.

The resources of the adult public mental health delivery system are targeted to adults with severe and serious mental illnesses. Within the resources available, the system will provide, at a minimum, a base level of service to all persons in the target population who seek services or who can be engaged through outreach activities. Additionally, as recommended in a study by the Public Consulting Group (PCG), priorities are established within target populations to guide the development and provision of specialty services and programs to people with the most significant disabilities. Recent advances in treatment for individuals with serious mental illness (SMI) and severe and persistent mental illness (SPMI) make it possible for individuals with these conditions to live far more satisfying lives than ever before. The system for adults with SPMI and SMI adopts a rehabilitation and recovery model focusing on providing or assisting individuals to obtain and maintain the skills they need to live as normally as possible in communities of their choice.

Adult Mental Health Target Populations for Community Services

Persons with severe and persistent mental illness (AMSPM)

People in this target population include adults, ages 18 and over, who meet diagnostic criteria and who as a result of a mental illness exhibit functioning that is so impaired as to interfere substantially with their capacity to remain in the community. The disability of these persons limits their functional capacities for activities of daily living such as interpersonal relations, homemaking, self-care, employment and recreation. The following diagnoses are included: schizophrenia, schizoaffective and schizophreniform disorders, bipolar disorder, major depressive disorder and psychotic disorder not otherwise specified. Functional status is assessed using the Global Assessment of Functioning (GAF).

Level of functioning criteria includes:

Any client who has or has ever had a GAF score of 40 or below.

OR

Current client who never had a GAF assessment when admitted

AND

Who without continued treatment and supports would likely decompensate and again meet the level of functioning criteria (GAF score of 40 or below).

OR

Current client who when admitted met level of functioning criteria but as a result of effective treatment does not currently meet level of functioning criteria

AND

Who without continued treatment and supports would likely decompensate and again meet the level of functioning criteria (GAF score of 40 or below).

OR

New client who does not currently meet GAF criteria and no previous GAF score is available and who has a history of:

- Two or more psychiatric hospitalizations.

OR

- Two or more arrests.

OR

- Homelessness.

Must be reassessed annually or with significant change in functioning.

NOTE: An individual can remain in the target population even though his/her level of functioning might improve beyond the initial GAF score of 40.

Persons with serious mental illness (AMSMI)

These are people 18 years or older who have a mental, behavioral, or emotional disorder that can be diagnosed and substantially interferes with one or more major life activities. These include delusional disorders, shared psychotic disorders, dissociative disorders, factitious disorders, obsessive-compulsive disorders, phobias, dysthymic disorder, borderline personality disorder, pedophilia, exhibitionism, anorexia, bulimia, post traumatic stress disorder, impulse control disorder and intermittent explosive disorder. Functional status is assessed using the GAF.

Adult, ages 18 and over, who meets diagnostic criteria and level of functioning criteria include:

Any client who has or has ever had a GAF score of 50 or below.

OR

Current client who never had a GAF assessment when admitted

AND

Who without ongoing treatment and supports would likely decompensate and again meet the level of functioning criteria (GAF score of 50 or below).

OR

Current client who when admitted met level of functioning but as a result of effective treatment does not currently meet level of functioning criteria

AND

Who without continued treatment and supports would likely decompensate and again meet the level of functioning criteria (GAF score of 50 or below).

OR

New client who does not currently meet GAF criteria and no previous GAF score is available, and who has a history of:

- Two of more hospitalizations.

OR

- Two or more arrests.

OR

- Homelessness.

Must be reassessed annually or with significant change in functioning.

NOTE: An individual can remain in the target population even though his/her level of functioning might improve beyond the initial GAF score of 50.

Adult deaf or hard of hearing (AMDEF)

Adult, ages 18 or over, assessed as having special communication needs because of deafness or hearing loss and having a qualifying mental health diagnosis.

Adult homeless – PATH (AMPAT)

Adult, ages 18 and over, with a serious long-term mental illness or a serious long-term mental illness and substance abuse diagnosis, and is:

- Homeless, as defined by:
 - (1) Lacks a fixed, regular and adequate nighttime residence.

OR

- (2) Has a primary night-time residence that is:

- (a) Temporary shelter.

or

- (b) Temporary residence for individuals who would otherwise be institutionalized.

or

- (c) Place not designed/used as a regular sleeping accommodations for human beings.

OR

- At imminent risk of homelessness as defined by:
 - (1) Due to be evicted or discharged from a stay of 30 days or less from a treatment facility.

AND

- (2) Who lacks resources to obtain and/or maintain housing.

Must be reassessed annually.

Priority Populations within Target Populations (This is an all inclusive list.)

- **Persons with multiple diagnoses:** Persons 18 or older with a severe and persistent mental illness and a diagnosis of substance abuse and/or mental retardation or serious health problem including HIV disease.
- **Mentally ill adults in the criminal justice system:** Persons 18 or older with serious mental illness that are released from the Division of Prisons, or are in local jails or on probation.
- **Elderly persons:** Persons age 65 and over with a serious mental illness, including dementia.
- **Deaf mentally ill persons:** Persons 18 or older with a mental, behavioral or emotional disorder that can be diagnosed who need specialized services provided by staff who have American Sign Language skills and knowledge of deaf culture.
- **Minorities:** Adults with severe and persistent mental illness who are disproportionately represented in the system.

Adult Mental Health Target Populations for State Hospitals

In the next five years, state hospitals should revise their complement of beds and services to focus on their mission of providing psychiatric inpatient care to individuals with severe mental illness who cannot be appropriately treated in their local communities. Efforts already underway to prevent unnecessary institutionalization by directing people to local service providers whenever possible will continue.

Primary populations to be served among state hospitals

- Adults with psychiatric illness including schizophrenia spectrum, bipolar disorder, major depression and some personality disorders, requiring brief acute inpatient treatment of a few days to stabilize and return to their communities.
- Adults with psychiatric illness including schizophrenia spectrum, bipolar disorder, major depression and some personality disorders, requiring long-term inpatient rehabilitative

treatment of approximately three to six months, to prevent or correct a rapid relapse and readmission cycle, or who remain dangerous to self or others.

- Children with severe emotional disorders requiring acute inpatient treatment to stabilize and return to a less restrictive environment.
- Older adults with psychiatric illness including schizophrenia spectrum, bipolar disorder, major depression and some personality disorders requiring acute inpatient treatment to stabilize and return to their communities.
- Adults with psychiatric illness and substance abuse disorders, or serious illness such as HIV requiring acute and/or longer-term inpatient treatment to stabilize and prevent rapid relapse and readmission.

Specialty populations to be served

- Forensic patients, including those found incapable of proceeding with court trials (House Bill 95), not guilty by reason of insanity and other detainees.
- Patients taking part in a research protocol.
- Deaf consumers requiring acute or long-term inpatient psychiatric services.

Adult Mental Health Target Populations the NC Special Care Center

The mission of the NC Special Care Center is to provide intermediate and skilled nursing care for individuals referred from state hospitals and for people who can't be served in their communities because of insufficient bed-space and insufficient psychiatric services of the intensity needed.

Primary populations to be served

- Consumers with severe mental illness requiring ICF level of nursing care (intermediate care facility).
- Consumers with severe mental illness requiring SNF level of nursing level care (skilled nursing facility).

Specialty population to be served

Consumers with mid-stage Alzheimer's disease requiring nursing care.

Child Mental Health

North Carolina conservatively estimates 10 to 12 percent of the state's children experience serious emotional disturbance (SED). This is based on the prevalence rate cited in the Federal Register, June 1998. The NC Office of State Budget and Management estimates that there are 1,964,047 children in North Carolina under age 18 based on U.S. 2000 census data. The number of children in this age group with SED is between 196,404 and 235,686.

Seriously emotionally disturbed child with out-of-home placement (CMSED)

Child, under the age of 18, with atypical development (up to age 5) or serious emotional disturbance (SED) as evidenced by the presence of a diagnosable mental, behavioral or emotional disturbance that meets diagnostic criteria specified in ICD-9.AND

Functional impairment that seriously interferes with or limits his/her role or functioning in family, school or community activities as indicated by one or more of the following:

- CAFAS score of at least 90; **OR**
- Total CAFAS score is greater than or equal to 70 and it is determined that appropriate functioning depends on receiving a specific treatment and withdrawal would result in a significant deterioration in functioning; **OR**
- In need of specialized services from more than one child-serving agency (e.g. mental health provider(s) and DSS, DPI/schools, DJJDP, DPH, DCD or health care).

AND

Placed out of the home or at risk of out-of-home placement, as evidenced by any of the following:

- Utilizing or having utilized acute crisis intervention services or intensive wraparound services in order to maintain community placement within the past year.
- Having had three or more psychiatric hospitalizations or at least one hospitalization of 60 continuous days within the past year.
- Having had DSS substantiated abuse, neglect or dependency within the past year.
- Having been expelled from two or more daycare or pre-kindergarten situations within the past year.
- Having been adjudicated or convicted of a felony or two or more Class A1 misdemeanors in juvenile or adult court or placed in a youth development center, prison, juvenile detention center or jail within the past year.
- Situation exacerbated by special needs (e.g. physical disability that substantially interferes with functioning).

NOTES: This target population was designed to cross walk with Level D in the Child Levels of Care document (March 2002). For additional information please refer to this document.

Also for additional clarification regarding specific terminology used in eligibility determination, please refer to the Child Mental Health IPRS Eligibility Clarification document.

An individual determined eligible for this target population will have priority for funding if identified as:

- Sexually aggressive; and/or
- Deaf; and/or
- Having co-occurring disorders.

Seriously emotionally disturbed child (CMMED)

Child, under the age of 18, with atypical development (up to age five) or serious emotional disturbance (SED) by the presence of a diagnosable mental, behavioral or emotional disturbance that meets diagnostic criteria specified in ICD-9;

AND

Functional impairment that seriously interferes with or limits his/her role or functioning in family, school or community activities as evidenced by one or more of the following:

- CAFAS score of at least 60; **OR**
- Total CAFAS score greater than or equal to 40 and it is determined that appropriate functioning depends on receiving a specific treatment and withdrawal would result in a significant deterioration in functioning.

NOTES: This target population was designed to cross walk with Level C in the Child Levels of Care document (March 2002). For additional information, please refer to this document.

Deaf or hard of hearing child (CMDEF)

Child, under the age of 18, who is assessed as deaf or as needing specialized mental health services due to social, linguistic or cultural needs associated with individual or familial deafness or hearing loss;

AND

The presence of a diagnosable mental, behavioral or emotional disturbance that meets diagnostic criteria specified in ICD-9.

NOTES: Deaf children will be dually enrolled as both Deaf/HH and in their appropriate population category, or order to receive a full array of services. Where this funding is available, it will be depleted before other funding sources pay for the eligible service.

Homeless child – PATH (CMPAT)

Child, under the age of 18, who has serious emotional disturbance (SED) and has an ICD-9 diagnosis(es) and is;

Homeless, as defined by:

- Lacks a fixed, regular, adequate night-time residence; **OR**
- Has a primary night-time residence that is:
 - (a) Temporary shelter; **or**
 - (b) Temporary residence for individuals who would otherwise be institutionalized; **or**
 - (c) Place not designed/used as a regular sleeping accommodations for human beings.

OR

At imminent risk of homelessness as defined by:

- Due to be evicted or discharged from a stay of 30 days or less from a treatment facility

AND

- Who lacks resources to obtain and/or maintain housing.

NOTES: There is no specific requirement regarding functioning as measured by a CAFAS score. Assertive outreach can be provided to homeless persons who have a deferred diagnosis.

Developmental Disabilities

The Division's developmental disabilities services follow recommendations of the National Association of State Directors of Developmental Disabilities Services and use the University of Minnesota's figure of 1.58 percent as a broad estimate of people in the total population with developmental disabilities. This means that there are approximately 130,810 people in NC with developmental disabilities.

Adult with developmental disability (ADSN)

Adult, ages 18 and over, screened eligible as developmentally disabled in accordance with the current functional definition in G.S. 122C-3(12a).

Developmental disability assessment based on NC SNAP 1 through 5.

NOTES:

Developmental disability means a severe, chronic disability of a person that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- Is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and,
- Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services that are of a lifelong or extended duration and are individually planned and coordinated.

Child with developmental disability (CDSN)

Child, under the age of 18, screened eligible as developmentally disabled in accordance with the current functional definition in G.S. 122C-3(12a).

Developmental disability assessment based on NC SNAP 1 through 5.

NOTES: Developmental disability means a severe, chronic disability of a person that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments;

- Is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and,
- Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services that are of a lifelong or extended duration and are individually planned and coordinated.

Developmental Disabilities Target Population for Community Services

In the late 1980's, North Carolina adopted the federal functional definition of developmental disability, which in essence targeted the population to those most impacted by disability. While this definition presumes that mental illness is not the cause or origin of the primary disability, it is acknowledged that those individuals who meet this functional definition may experience a co-occurring mental illness.

Developmental disability services are provided throughout a broad and diverse population. The target population is created by the application of a functional rather than diagnostic definition and is applicable throughout the lifetime of most individuals who are eligible for services. Since people with developmental disabilities, uncomplicated by secondary conditions, do not have an illness that is amenable to medical treatment, services and supports for these individuals focus almost entirely on interventions that strengthen the individual's ability to manage community living conditions and maintain or build a reliable personal support system.

All people currently in services meet the target population criteria, but they may be receiving services/supports in excess of or inappropriate to their level of need. The requirement in the new system for re-assessment of individuals already receiving services is to correct any inappropriate or excessive services that currently exist.

Substance Abuse

Data used in making projections of treatment needs are taken from North Carolina's first Center for Substance Abuse Treatment (CSAT) needs assessment studies conducted by the Research Triangle Institute. Estimates of people needing substance abuse services include:

- 784,000 people age 18 and above who needed substance abuse services.
- 2,600 homeless.
- 2,700 psychiatric patients.
- 9,700 imprisoned believed to be in need of substance abuse services.
- 47,555 public high school students.
- 4,917 school dropouts.
- 666 private school students.

Substance Abuse Target Population

The most significant opportunity to reduce the burden of substance abuse on public programs is through targeted and effective prevention programs. If children and youth under age 21 can be kept from smoking cigarettes, using illicit drugs and abusing alcohol, the risk for future addiction is substantially reduced. Treatment is also a cost-effective intervention, as it reduces the costs to state programs in the short term and avoids future costs. North Carolina will make targeted interventions for selected populations that hold promise for high return. As savings and new resources become available to expand service system capacity, additional populations will be added to the list of those targeted for services.

Target populations for substance abuse services (eligibility criteria)

All individuals will be assessed for service eligibility on the basis of the American Society of Addiction Medicine (ASAM) patient placement criteria for the treatment of substance-related disorders (PPC).

Adult Substance Abuse

Adult injecting drug user/communicable disease (ASCDR)

Injecting drug users, those with communicable disease and/or those enrolled in opioid treatment programs, are those adults who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, and:

- Who are currently (or within the past 30 days) injecting a drug under the skin, into a muscle or into a vein for non-medically sanctioned reasons and who meet ICD-9 criteria for a substance-related disorder.

OR

- Who are infected with HIV, tuberculosis or hepatitis B, C or D and who meet ICD-9 criteria for a substance-related disorder.

OR

- Who meet ICD-9 criteria for dependence to a opioid drug, are addicted at least one year before admission, are 18 years of age or older, and who are enrolled in an opioid treatment program.

Adult substance abuse women (ASWOM)

Adult women who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, with an ICD-9 substance-related disorder who are:

- Currently pregnant.

OR

- Have dependent children under 18 years of age.

OR

- Who are seeking custody of a child under 18 years of age.

Adult substance abuse DSS-involved parents (ASDSS)

DSS involved adults who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, and are substance abusers who meet ICD-9 criteria for substance-related disorder include those who:

- (1) Are parents who have legal custody of a child or children under 18 years of age.

AND

- (2) Where there is a Child Protective Services report for child abuse, neglect or dependence that is being assessed, or where there is a finding of a need for Child Protective Services or a case decision of substantiation by Child Protective Services, OR who are authorized by DSS to receive Work First Assistance and/or services.

OR

- (1) Are DSS involved individuals who have been convicted of a Class H or I Controlled Substance Felony in North Carolina, and who are applicants for or a recipient of food stamps.

Adult substance abuse high management (ASHMT)

High management adult substance abusers, who are in need of treatment for a primary alcohol or drug abuse disorder, with an ICD-9 substance dependence disorder, are those individuals who are ages 18 and over, and who:

1. Are currently involuntarily committed to substance abuse treatment (legally determined to be dangerous to self or others and may have co-occurring mental illness).

OR

2. Have a substance use pattern of recurring episodes of chronic use with unsuccessful attempts at recovery (or unsuccessful attempts by the provider to engage the chronically ill individual in treatment).

AND

Have a history of one or more unsuccessful treatment episodes, which may include assisted detoxification. The individual is advanced in their disease, has limited social or environmental supports, and has few coping skills. The individual may also be resistive to treatment, or have co-occurring disorders, or have moderate biomedical conditions.

Adult substance abuse criminal justice offender (ASCJO)

Substance abusing adult clients who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, who are involved in the criminal justice system, and:

1. Who meet ICD-9 criteria for a substance-related disorder;

AND

2. Whose services are approved by a TASC program care manager;

AND

3. Who voluntarily consent to participate in substance abuse treatment services;

AND

4. Who are Intermediate Punishment offenders OR who are Department of Correction releasees (parole or post-release) who have completed a treatment program while in custody OR who are Community Punishment Violators at-risk for revocation.

Adult substance abuse driving while impaired treatment (ASDWI)

Adults, ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, who have an ICD-9 substance-related disorder and:

1. Have been arrested for:
 - Driving while impaired (DWI), **OR**
 - Commercial DWI, **OR**
 - Driving while less than 21 years old after consuming alcohol or drugs.

AND

2. Must have completed a DWI assessment and been identified with a substance abuse handicap.

AND

3. Client must pay for initial \$125 in fees for assessment and treatment.

AND

4. Have an income level of 200% or less of the federal poverty level.

Note: The intent of this eligibility category is to provide necessary access to treatment for eligible individuals who cannot pay for services through first or third party payment and who are seeking substance abuse treatment that is required in order for the individual to obtain a Certificate of Completion required under General Statute as a condition for the restoration of a driver's license.

Adult substance abuse deaf and hard of hearing (ASDHH)

Adult clients who are ages 18 or over, who are in need of treatment for a primary alcohol or drug abuse disorder, and who have an ICD-9 substance-related disorder and who have been assessed as having special communication needs because of deafness or hearing loss.

Adult substance abuse homeless (ASHOM)

Adult clients who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder and who meet the criteria for any of the following IPRS target population categories:

- Injecting drug user/communicable disease risk (ASCDR)
- Criminal justice offender (ASCJO)
- DSS-involved (ASDSS)

- DWI treatment (ASDWI)
- High management (ASHMT)
- Women (ASWOM)
- Deaf and hard of hearing (ASDHH)

AND IS

Homeless, as defined by:

1. Lacks a fixed, regular and adequate nighttime residence.

OR

2. Has a primary night-time residence that is:
 - Temporary shelter, **or**
 - Temporary residence for individuals who would otherwise be institutionalized, **or**
 - Place not designed/used as a regular sleeping accommodations for human beings.

OR

At imminent risk of homelessness as defined by:

1. Due to be evicted or discharged from a stay of 30 days or less from a treatment facility.

AND

2. Who lacks resources to obtain and/or maintain housing.

Child and Adolescent Substance Abuse

Child with substance abuse disorder (CSSAD)

Child or adolescent, under the age of 18, who is in need of treatment for a primary alcohol or drug abuse disorder, with a primary ICD-9 substance-related disorder.

Child Substance Abuse Women (CSWOM)

Adolescent women who are under the age of 18, who are in need of treatment for a primary alcohol or drug abuse disorder, with a primary ICD-9 substance-related disorder, and who are:

- Currently pregnant.

OR

- Have dependent children under 18 years of age in her custody or for whom she is seeking such custody.

Child substance abuse selective prevention (CSSP)

A child or adolescent under 18 years of age determined to be at elevated risk for substance abuse and who:

- Is currently experiencing, or in the previous six months has experienced, documented school related problems or educational attainment difficulties including school failure, truancy, suspension or expulsion or dropping out of school

OR

- Has documented negative involvement within the previous six months with law enforcement or the courts including formal and informal contacts such as arrest, detention, adjudication, warning, or escort.

OR

- Has one or both parents, legal guardians, or caregivers that have one or more documented child abuse or neglect reports, investigations or substantiated incidents involving DSS.

OR

- Has one or both parents, legal guardians, or caregivers that have a documented substance-related disorder.

NOTE: Individuals do not meet criteria for a substance-related disorder or a mental health disorder, but may meet the criteria for other conditions that may be a focus of clinical attention. Recipients will be individually identified, client records will be maintained, and designated consumer prevention outcomes will be tracked.

Child substance abuse indicated prevention (CSIP)

Child or adolescent under 18 years of age who is using alcohol or other drugs at a pre-clinical level (child or adolescent does not meet criteria for a substance-related disorder or a mental health disorder, but may meet other criteria) and who:

- Is currently experiencing, or in the previous six months has experienced, documented school related problems or educational attainment difficulties including school failure, truancy, suspension or expulsion or dropping out of school.

OR

- Has documented negative involvement within the previous six months with law enforcement or the courts including formal and informal contacts such as arrest, detention, adjudication, warning or escort.

OR

- Has one or both parents, legal guardians or caregivers that have one or more documented child abuse or neglect reports, investigations or substantiated investigations involving DSS.

OR

- Has one or both parents, legal guardians or caregivers that have a documented substance-related disorder.

NOTE: Individuals do not meet criteria for a substance-related disorder or a mental health disorder, but may meet other criteria. Recipients will be individually identified, client records will be maintained, and designated consumer prevention outcomes will be tracked.

Child substance abuse criminal justice offender (CSCJO)

Substance abusing adolescent clients who are under the age of 18, who are in need of treatment for a primary alcohol or drug abuse disorder, and who are involved in the criminal justice system and:

- Who have a primary ICD-9 substance-related disorder.

AND

- Whose services are authorized by a TASC program care manager.

AND

- Who voluntarily consent to participate in substance abuse treatment services.

AND

- Who are Intermediate Punishment offenders OR who are Department of Correction releasees (parole or post-release) who have completed a treatment program while in custody OR who are Community Punishment Violators at-risk for revocation.

Child substance abuse DWI Treatment (CSDWI)

Adolescents under the age of 18, who are in need of treatment for a primary alcohol or drug abuse disorder, who have a primary ICD-9 substance-related disorder and:

- Have been arrested for:
 - Driving while impaired (DWI), **or**
 - Commercial DWI, **or**
 - Driving while less than 21 years old after consuming alcohol or drugs.

AND

- Must have completed a DWI Assessment and been identified with a substance abuse handicap.

AND

- Client must pay for initial \$125 in fees for assessment and treatment.

AND

- Have an income level of 200% or less of the federal poverty level.

NOTE: The intent of this eligibility category is to provide necessary access to treatment for eligible individuals who cannot pay for services through first or third party payment and who are seeking substance abuse treatment that is required in order for the individual to obtain a Certificate of Completion required under General Statute as a condition for the restoration of a driver's license.

Child in the MAJORS substance abuse/juvenile justice program (CSMAJ)

Child or adolescent, under the age of 18, who is in need of treatment for a primary alcohol or drug abuse disorder, with a primary ICD-9 substance-related disorder.

AND

Is enrolled in the MAJORS substance abuse/juvenile justice program.

Priorities within Target Populations

- Adult and child pregnant injecting drug users.
- Adult and child pregnant substance abusers.
- Adult and child injecting drug users.
- Children and adolescents who are involved in the juvenile justice or the social services system, who are having problems in school or whose parent(s) are receiving substance abuse treatment services.
- Adult and child deaf persons who need special services provided by staff who have American Sign Language skills and knowledge of the deaf culture.
- Adult and child clients who have co-occurring physical disabilities.
- Adult and child homeless clients
- All others.

Persons with Substance Abuse and Mental Illness

LMEs will be required to ensure that services are provided to individuals who experience substance abuse problems along with co-existing physical or cognitive disability. All services to adults with multiple disorders should address both the mental health and substance abuse needs in a coordinated, integrated manner. The primary responsibility shall be assigned as described here:

- Adult mental health services shall have primary responsibility for mentally ill individuals who also abuse substances. This includes adults who have a diagnosis of severe and persistent mental illness, including schizophrenia, bipolar disorder, schizoaffective disorder, recurrent major depression or borderline personality disorder, and in addition have a substance abuse problem.
- Substance abuse services shall have primary responsibility for consumers with substance abuse/dependence disorders who also have a mental illness. This includes adults who carry a diagnosis of substance abuse/dependence and, in addition, have a mental health diagnosis other than those listed above, which could include other Axis II disorders.

Chapter 3: Supporting and Serving Our Citizens

Building a system of supports, treatment and services for people with disabilities that makes it possible for them to live meaningful and satisfying lives in communities of their choice is a gradual process influenced by many considerations. Progress needs to occur on a number of fronts simultaneously, such as building infrastructure, developing community capacity and acquiring skills needed to apply best practice models that are shown to result in positive outcomes for people. The changing system must also continue to provide needed services to people without interruption during the change process and support them through the transition periods. The first step must be to develop community capacity. In order to accomplish this, there must be a reduction in the system reliance on institution/facility care. In addition, the philosophy of supporting and serving people must move to a person-centered support and treatment approach and real life outcome oriented system.

These steps will result in transitions from state-operated institutional services to community-based supports and services. The Division will ensure that clients who transition to the community will receive services that are equal to or better than those received in the institution. In addition, the types of supports and services currently offered in the community will become state-of-the-art practices that are ultimately supported through evidence-based and best practice models that are proven to be the best methods of response for people identified in the target population as well as referred through the uniform portal.

This chapter begins with a presentation of person-centered planning, as it applies to all populations. The second major section is the description of case management. Particular models of case management are included in the disability specific best practices. The final major sections are presentations of best practice for each disability group. A resource listing for the best practice areas for each of the four disability groups (adult mental health, child mental health, developmental disabilities and substance abuse) are included as appendix A.

Person-Centered Planning

At the heart of the reform efforts is person-centered planning. Person-centered planning is the life planning process that applies across all citizens who are supported and served. Person-centered planning is not a program. Person-centered planning is a life planning method (process) of determining ends (real life outcomes) for individuals and developing means to those ends (strategies).

Process

There are four key models of practice that are recognized as legitimate, person-centered planning methods: Essential Lifestyle Planning (ELP), McGill Action Planning System (MAPS), Personal Futures Planning (Futures) and Planning for Alternative Tomorrows (PATH). Wraparound is also

recognized as a person-centered planning process for families and children. A particular method is chosen based on an individual's life circumstances, situation and condition.

All of these methods have key similarities. They all involve a process of negotiation. All of the methods are dynamic; they occur on an "as needed" basis. Also, they all use a quality improvement process that involves continuously monitoring progress and using the resulting information and data to continuously improve the plan to assure the achievement of desired outcomes. In addition, any legitimate person-centered planning process contains certain core components. The person-centered planning process and person-centered plan must:

- Be driven and owned by the individual with the disability.
- Involve a sustained commitment to the life of the individual with the disability.
- Be strengths-based.
- Include both a proactive and reactive crisis contingency plans.
- Include reasonable assurances of health and safety.
- Contain strategies that reflect the most natural, durable and sustainable methods of achieving the outcomes.
- Be "real life" outcome oriented.

Real life outcomes

Real life outcomes are defined as related to life domains and are intended to reflect the most natural, durable and sustainable life of an individual – community inclusion. Examples include housing, career and vocational, educational, health, clinical, social, intimate relationships, friendships, spiritual, civic and economic dimensions. The number of life domains that need to be addressed at any point in time may vary, but as many as possible should be examined. In addition, strategies to address life domains should include consideration of how strategies can be integrated around the individual as well as how individual outcomes may be integrated with other outcomes (developing relationships and employment, as examples).

Strategies

Strategies are the methods that are intended to promote the achievement of the outcomes. Strategies are to be considered in the following order:

- **Personal resources:** Resources can be strengths such as concrete things that we have the ability and willingness to contribute or priceless attributes about ourselves or family that see us through to happier times. Other personal resources include financial resources possessed by the individual. This does not include driving people further into poverty.
- **Natural supports:** People most closely associated with the individual. This does not include "dumping" on natural supports.
- **Natural community resources:** People, places, social institutions and systems available to all people in the community. This does not include "dumping" on the community.

- **Specialty community resources:** People, places, social institutions and systems that are specifically intended and designed for accommodating and supporting people with disabilities. This includes other entitlements, designated resources and other legally oriented provisions (housing, school and vocational, as examples). This does not include inappropriate "cost shifting" in any direction.
- **Specialty supports and services:** Publicly sponsored provisions of support, service and treatment.

It is critical that the development of the person-centered plan does not become the outcome. The person-centered plan is the map that guides the individual and his/her natural supports, personal and community resources and publicly sponsored specialty supports, services and treatment to move towards his/her real life outcomes.

Case Management

Case management models are central to serving people with the most severe forms of mental illness, developmental disabilities and substance abuse and children with severe emotional disturbance. Individuals with less severe forms of mental illness, developmental disabilities and substance abuse and individuals actively recovering from mental illness and substance abuse require much less case management. In fact, many individuals with mental illness and/or substance abuse will require no case management at all. A hallmark of their recovery is that they truly become their own life managers. Case management models (e.g. assertive community treatment, intensive family intervention, community support program and varieties of wraparound) are designed to respond to the needs of people who have not benefited from the traditional service delivery system, i.e., categorical services. Categorical services are meant to respond to the needs of a category of people, not an individual's unique needs.

The case management function is key to the development and operation of participant-driven, outcome oriented, cost-effective human services system. With a central adherence to an advocacy perspective, case management is a service function delivered by providers that applies five dynamic and interrelated processes of assessment, planning, linking, coordinating and monitoring. These activities are all recipient specific and therefore require that the individual case manager have an ongoing relationship with the individual customer. Carrying out these five processes results in the preparation and implementation of a person-centered plan (PCP) through a person-centered planning process. Ultimately, the case management function is to assure that a person-centered planning process occurs for each customer and that the services/supports/treatments, formal and informal, specialty and non-specialty, are delivered/acquired in accordance with the plan.

There are several population-specific case management models of practice that are included within the models of best practice included in this chapter. Each varies in the manner in which the five processes are carried out and the corresponding skill set requirements. Variations in model selection depends on the nature and type of disability (mental illness, developmental disability, severe emotional disturbance and substance abuse) individual life circumstances, situations and conditions (life domain related) and individual history (past success with particular models).

Examples in variations of individual models include support coordination, clinical case management and intensive case management. These models include variations in types of professionals (e.g. substance abuse specialist, social workers and nurses), caseload size (staff-to-client ratios) and primary location of service (e.g. clinic or community). Examples in variations of comprehensive case management models nationally include assertive community treatment, intensive family intervention and community support program.

Case managers must have the skill sets necessary to respond to each individual's unique strengths and needs. This is best achieved by the fundamental competencies in the following categories.

Values related

- Believes that people are in command of their life and have priorities that are just as important as what professionals think.
- Believes that consumers are full citizens and deserve to be supported in the least restrictive environment.
- Believes that all children have the right to grow up in a family and in the community. (Some children may need brief out of home placements, but the case manager closely monitors the care and works toward transition back to their community.)
- Is culturally proficient and sensitive (i.e., speaks appropriate language and does not judge family culture).
- Adheres to the most efficient use of public resources.

Plan related

- Learns from consumers who is important to them in their lives as well as those who should be involved in the person-centered plan (e.g. significant others, family and caregivers members, friends, employer, social services worker, schoolteacher, probation officer, housing authority personnel, etc.).
- Helps the consumer configure those important people so that planning can begin.
- Using a person-centered planning process, develops a person-centered plan (PCP) with the consumer/family that identifies real life outcomes and utilizes the consumer, family/friend and community strengths as strategies.
- Assists consumers/family with looking across life domains to establish priorities in planning.
- Skilled at and takes responsibility for proactive and reactive crisis planning and safety planning.
- Knows the difference between needs and services.
- Utilizes services as strategies after all other alternatives that are more durable have been discussed. Doesn't jump to services to meet every need. Instead, can develop durable supports (e.g. a parent network that exchanges respite with one another or a social network where self esteem is built naturally such as church choir, bowling leagues, sewing clubs, community play houses, empowerment groups at the YMCA or YWCA, etc.), as opposed to a therapeutic intervention by a professional.
- Implements, coordinates and manages all aspects of the PCP.

Specialty supports and services related

- Requests for authorization and re-authorization by providers are coordinated with the case manager before formal requests go to the LME. (This involves ongoing coordination of the provider network at the micro level.)
- With the consumer/family, makes connections with other service providers in the network to be utilized as strategies to accomplish outcomes already identified in the PCP.
- Monitors the services provided by the network in terms of performance and progress toward outcomes identified in the PCP.
- Advocates for consumers to receive quality services from the network.
- Plans for, identifies and advocates for consumers to “step down” from more intensive formal services when appropriate.

Advocacy and community related

- Pursues the securing of all resource entitlements (e.g. Medicaid, food stamps) and other public and community resources – formal and informal, paid and unpaid.
- In addition to assisting non-Medicaid consumers in applying for Medicaid, helps each consumer through all levels of appeal.
- Has the skills to coordinate with physical health providers regarding medication, side effects, etc., whether these providers are furnishing these services through an integrated model in which the case manager participates, or is a member of the network furnishing these services in combination with other discrete services, such as therapy.
- Develops transition plans for changes in level of care.
- Is available after hours for first response crisis management. (Case managers within a network may establish an on-call system where they share crisis plans and rotate after hours coverage.)

Adult Mental Health – Best Practice

This section is presented in two sequential components: the foundations for all practice and a description of the best practice models. Best practice programs, services and supports are well implemented, scientifically defensible, supported by formal evaluation and research, have documented evidence of significant national consensus among experts in the field, and have demonstrated effectiveness and positive outcomes for consumers and their families.

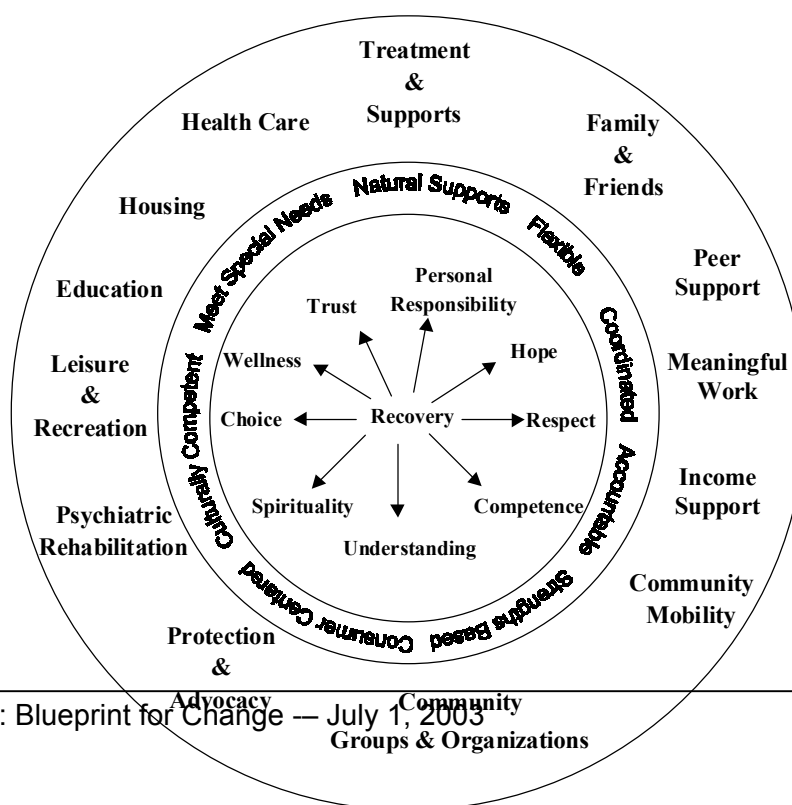
Foundation: Recovery Oriented Supports and Services

The concept of “recovery” is the foundation of all system efforts and best practice models. The concept of recovery has been traditionally associated with the alcohol and substance abuse recovery movement emphasizing self-help, mutual support and fellowship. Over the past several decades, recovery has emerged as a foundation on which best practice interventions for adults with serious mental illness are designed. For mental illness, the recovery approach can be compared somewhat to a person who undergoes a serious accident or illness and recovers from the acute event but retains some lingering residual effects or functional problems. There are five essential elements of recovery:

- Instillation of hope, a positive sense of self and a positive outlook for the future.
- Focus on strengths.
- Empowerment.
- Self-determination.
- Meaningful work and roles in life.

Recovery oriented supports and services facilitate a process whereby consumers define their strengths and goals and create meaningful lives and roles beyond that of “psychiatric patient.” Recovery oriented supports and services incorporate a tolerance for “set backs,” understand that the recovery process is not simple or linear and are provided in a care environment that is flexible enough to allow for the ups and downs of the illness. In a recovery framework, clinical decisions are evidence based, but always in the context of partnership and person-centered planning, which requires personal choice and a match of supports and services that respects individual needs and goals. Research has demonstrated that this approach results in positive treatment outcomes and high client satisfaction.

The illustration below shows the way in which the concept of recovery for adults with severe and persistent mental illness is essential to implementing reforms that are consistent with the State Plan vision and principles.



Best Practice Supports and Services

There is remarkable consensus around “best practice” supports and services for adults with severe and persistent mental illness. Those best practice services that have empirical evidence of efficacy are considered to be evidence-based practice. A national project supported by the Robert Wood Johnson Foundation has developed a series of evidence-based practice (EBP) tool kits. The EBP tool kits include sections for administrators, practitioners, consumers and families. They include training modules and they include evaluation instruments to assess fidelity to the model of practice. It is the intent of the Division that the services identified through the EBP tool kits are a priority. As soon as the tool kits are available to providers, the LMEs should utilize the tool kits in the development of these services, provide training based on the tool kits and utilize the evaluation tools through the LME’s quality improvement responsibility to ensure fidelity to the model of service throughout the provider network.

Services for which EBP tool kits are available are:

- Medication management.
- Illness self-management.
- Integrated dual disorder treatment.
- Supported employment.
- Family psycho-education.
- Assertive community treatment.

Additional information regarding these six evidence based practices is available at <http://mentalhealthpractices.org> and other web sites listed in appendix A. While these evidence-based practice services should be given priority, they do not constitute the full array of best practice services. A list of best practice services by dimension is shown on the following pages. Essential elements of a best practice service are listed as well as characteristics of individuals who benefit most from this particular service. Services that have an EBP Tool Kit available are indicated with ***.

DIMENSION: CASE MANAGEMENT/ACT

Intensive Case Management

- **Essential Elements**

- Consumers are linked with all services, benefits and entitlements for which they qualify and that they choose to receive.
- Case manager helps with application process and advocates for entitlements, if consumer experiences a barrier to service or entitlement access, and monitors ongoing connection between consumer and entitlement/service.
- Case manager also partners with consumer to help connect with natural community supports and resources.
- Case manager to consumer ratio is maintained at approximately 1:25-30.
- Case management is provided within the context of a partnership relationship; the case manager provides support and problem-solving assistance, as needed.
- Case management occurs through community-based (rather than office based) contacts.
- 24/7 crisis response capacity for individuals being provided case management services.
- **Who Benefits**
 - Consumers with severe and persistent mental illness with multiple and/ or complex needs.

Assertive Community Treatment Teams***

- **Essential Elements**
 - Services provided by a team that is responsible for all client needs.
 - Team members share responsibility for all clients.
 - High team member to client ratio (roughly 8-10 clients per team member).
 - Services provided in clients' natural setting.
 - 24/7 coverage including as related to crisis response capacity for individuals being provided ACT services.
 - Shared caseloads among team members.
 - Flexible direct services.
 - Broad team skills and training (team has a psychiatrist, vocational specialist, nurse, SA specialist, etc.).
 - Client advisory mechanisms that provide oversight of the service.
- **Who Benefits**
 - Clients with high utilization:
 - Long periods in the hospital.
 - Frequent hospitalizations.
 - Repeated emergency room visits.
 - Clients with severe impairment in psychosocial functioning.
 - Homeless clients.
 - Criminal justice system.

DIMENSION: MENTAL HEALTH TREATMENT

Medication Management***

- **Essential Elements**
 - Rational step-wise, evidence-based approaches to symptom management.
 - Algorithms to approach the severe mental disorders.
- **Who Benefits**
 - Clients receive state-of-the-art medication management.
 - Clients are assured that treatment is based on a common knowledge base across the state.

Assessment

- **Essential Elements**
 - Telephone contact with clinician, and capacity for face-to-face 24/7, with contact for emergency care within 1 hour; urgent care w/in 48 hrs. and routine care within 7 days.
 - Should be done by a qualified professional receiving regular supervision, cross-trained in adult MH and SA across all age groups (i.e. young adult, adult, geriatric).
 - Must have access to psychiatrists, clinicians with expertise in MR/DD, and interpreters as needed, with explicit criteria for when these professionals are consulted.
 - Screening results in triage for determination of 1) emergent, urgent, or routine care; 2) appropriate and timely clinical referrals; 3) immediate medical evaluation; and 4) referral to social supports. Assessment verifies these determinations.
 - Assessment results in a diagnosis, case formulation, and initial treatment plan.
 - Assessment includes all clinically relevant information from the following areas: 1) chief complaint/ reason for referral; 2) history of present illness; 3) past MI/DD/SA history – with particular awareness for potential multiple disorders such as MI/SA; 4) mental status exam; 5) medical history; 6) substance abuse history; 7) family/marital/ relationship history; 8) psycho-social /developmental history; 9) involvement with criminal justice system; 10) occupational history; 11) educational history; 12) functional assessment, including ability to complete activities of daily living; 13) potential barriers to treatment; 14) strengths and resources; 15) socio-cultural diversity issues.
- **Who Benefits**
 - All clients seeking mental health services.
 - All individual receiving mental health services.

Illness Self Management ***

- **Essential Elements**
 - Psycho-education about illness including diagnosis and symptoms, effects of medication, stress-vulnerability model, effects of alcohol and drugs.
 - Allows avoidance and minimization of relapses through recognition of early warning signs of relapse, avoidance of alcohol and drugs, regular sleep and exercise.
 - Promotes interdependence between the individual and treatment and service providers.
- **Who Benefits**
 - Likely all clients.
 - Clients at risk of symptom exacerbation, re-hospitalization and relapse have been shown particularly to benefit.

Integrated Dual Disorder Treatment***

- **Essential Elements**
 - Concurrent treatment of mental illness and substance abuse by the same clinicians that assume responsibility for treating both disorders.
 - Key features include assertive outreach, stage-wise treatment, harm-reduction approach, counseling, motivational interventions and social support interventions.
 - Must be linked with comprehensive mental health services, culturally sensitive and focused on long-term goals and recovery.
- **Who Benefits**
 - Likely to benefit all individuals with co-occurring disorders.
 - Research and state reform efforts thus far have focused on individuals with serious mental illness and co-occurring substance use disorders.
 - About 50% of individuals with serious mental illness have a co-occurring substance use disorder. Dual disorder treatment is very important.

DIMENSION: CRISIS RESPONSE SYSTEM

Crisis Response System

- **Essential Elements**
 - May be provided by a mobile team that provides in-home or community-based crisis responses and resolution services.
 - Staffed by multidisciplinary treatment team.
 - An alternative or complementary model utilizes community crisis centers staffed with multi-disciplinary teams with observation or brief stay capability.
- **Who Benefits**
 - Individuals who experience a mental health crisis.

DIMENSION: REHABILITATION SERVICES

Rehabilitation Skill Teaching

- **Essential Elements**
 - Establishing a partnership between service provider and consumer.
 - Helping the consumer choose a role and setting in which s/he would like to live, learn or work.
 - Identifying the skills and resources needed to be successful.
 - Helping the consumer learn the skills needed to reach goals & linking the person with the support/resources needed for success.
 - Can be done individually or in groups.
 - Should occur over several months.

- **Who Benefits**
 - Individuals with severe and persistent mental illness with interest in employment, independent living and/or education.

Social Skills Training

- **Essential Elements**
 - Modeling, role playing, positive and corrective feedback, homework use social learning principles to teach social skills.
 - Multiple weekly sessions.
 - Individual and group formats.
 - Training lasts 3 months to over a year.
 - Training occurs in client's natural setting.
- **Who Benefits**
 - Individuals with schizophrenia who have poor social functioning.

DIMENSION: FAMILY AND COMMUNITY SUPPORT

Family Psycho-education ***

- **Essential Elements**
 - Multiple successful formats (single or multiple family sessions; locations include clinics, homes, family practices & other community settings; techniques include didactic, cognitive-behavioral, and systemic).
 - Longer, more thorough programs are more successful to a point.
 - Key element of psychoeducation is its focus: it must be on expectations and common goal setting, social and clinical needs, education needs, communication needs, family strengths and weaknesses, stress-reduction, problem-solving, coping, crisis plans, skills training and other support.
 - Oriented to future, not to past.
- **Who Benefits**
 - Clients in regular contact with relatives more than 4 hours per week.
 - Clients with time and resource intensive needs: emotional support, case management, financial assistance, advocacy, housing, etc.
 - Clients with little support outside of their family.
 - Benefits of family psychoeducation confirmed for a broad range of disorders, including schizophrenia, schizoaffective disorder, bipolar disorder, major depression, obsessive-compulsive disorder, anorexia nervosa and borderline personality disorder.

DIMENSION: PEER SUPPORT

Mutual Support Groups

- **Essential Elements**
 - Consumers share support, hope, skills and problem solving strategies with other consumers.
 - Voluntary and consumer run, without mental health professional leadership.
- **Who Benefits**
 - People with severe and persistent mental illness wishing to connect with others around recovery.
 - Research has shown that members of mutual support groups report increased hope and self-understanding, longer community tenure and increased social integration.

Consumer Providers

- **Essential Elements**
 - Consumers work in mental health settings (often as case managers), or have independent consumer run programs such as drop-in centers, employment programs or residential programs.
 - Consumer providers are paid employees, with more formalized infrastructure and interaction with consumer clients than in mutual support groups.
- **Who Benefits**
 - People with severe and persistent mental illness receiving or desiring community based services.
 - Consumers who wish to work as service providers.

DIMENSION: RESIDENTIAL STABILITY

Housing

- **Essential Elements**
 - Independence: 1) People choose their housing, including location and model; 2) leases or occupancy agreements clearly outline tenant rights and responsibilities; 3) the provision of services is distinct from the housing.
 - Affordability: Tenants should not have to pay more than 30% of income for housing costs.
 - Accessibility: Must meet a range of accessibility needs including being physically accessible, being accessible to needed services and close to public transportation.
 - A range of housing options should be available including permanent and transitional housing, building- specific and scattered-site housing and housing ranging from single occupancy to shared living space.
- **Who Benefits**
 - All individuals with severe and persistent mental illness who need safe and stable housing.

Jail Diversion

- **Essential Elements**
 - Case management.
 - Training to work with individuals with mental illness.
 - Ongoing collaboration with local criminal justice for diversion as early as possible.

- Aggressive identification of appropriate cases within the first 24-48 hours of detention.
- Data systems to track individuals through criminal justice and mental health systems.
- **Who Benefits**
 - Individuals who have been diverted from incarceration.
 - Individuals whose incarceration has been shortened.
 - The community in general.

DIMENSION: VOCATIONAL

Supported Employment***

- **Essential Elements**
 - Focus on and commitment to competitive work.
 - Rapid job search and placement.
 - De-emphasis on pre-vocational training & assessment.
 - Attention to client preferences.
 - Places all that desire employment, regardless of disability or skills.
 - Follow-along supports provided indefinitely.
 - Integration with case management and clinical services.
- **Who Benefits**
 - Supported employment is the most effective vocational rehabilitation approach for all persons with mental illness, regardless of work experience or disability.
 - Employers who hire persons with disabilities.
 - Persons with disabilities who receive employment.

Other Critical Areas

The following areas should also be provided particular attention as part of the supports and services for adults with severe and persistent mental illness:

- **Psychiatric inpatient:** Best practice models include alternatives to episodes of inpatient psychiatric care. Individuals may require periodic psychiatric hospitalizations. It is imperative that the process of discharge planning initiate with the admission. This includes efforts intended on maintaining resources in the community to prepare for the person's discharge (housing, as a key example). Furthermore, the discharge itself should be a planned effort that ensures community supports and services are in place so the individual may connect with needed services immediately upon discharge. The person-centered plan crisis contingency component should address episodes of inpatient psychiatric care from admission to discharge.

- **Clubhouse models:** Clubhouse models such as psychosocial rehabilitation (PSR) and Fountain House provide an effective structure through which a number of best practices can be offered and integrated. For example, clubhouse models offer a structure for rehabilitation services and peer support. In planning the integrated system, the development of clubhouses as a structure to deliver best practice integrated services is strongly encouraged.
- **Integrated systems:** There are structures through which a number of the best practices can be offered and integrated. For example, as stated in the prior section, the clubhouse models (PSR and Fountain House models) offer a structure for rehabilitation services and peer support. Another example used in a number of states is the Community Support Program service definition that includes a number of these components in a single blended, active service performed by provider organizations. Planning the integrated system includes closely examining the various best practice models and applying said models into corresponding structures for delivery. This further advances the notion of integration between provider organizations as well as within particular support and service structures.

Child Mental Health – Best Practice

This section is presented in two sequential components: the foundations for all practice and a description of the best practice models. Best practice programs, services and supports are well implemented, scientifically defensible, supported by formal evaluation and research, have documented evidence of significant consensus among experts in the field, and have demonstrated effectiveness and positive outcomes for consumers and their families.

Foundation: Systems of Care

The State Plan requires that services to target populations reflect best practice. Accordingly, services for children and their families should be defined by outcomes that demonstrate (Surgeon General Report, 1999, President's New Freedom Commission, 2002) "achievement of expected developmental cognitive, social, and emotional milestones and by secure attachments, satisfying social relationships, and effective coping skills. Mentally healthy children and adolescents enjoy a positive quality of life; meet developmental milestones, function well at home, in school, and in their communities; and are free of disabling symptoms of psychopathology (Hoagwood et al., 1996)". Further, because children are not little adults, their services must be planned and delivered in the context of their social environments of family, peer group and schools/work and their larger physical and cultural surroundings. This is particularly true for children with moderate and severe emotional disturbances - diagnosed mental health problems that substantially disrupt a child's ability to function socially, academically, and emotionally.

The State Plan requires that services be provided and developed within a family-centered and strengths-based orientation, promoting community-based comprehensive responses for children with complex and significant functional impairment due to mental, emotional and behavioral problems, and their families. The concept of family-centered and comprehensive care is the

foundation of all system efforts and best practice models for children and their families (President's New Freedom Commission, 2002).

This approach serves the whole family, not just the child with an emotional disturbance. It is based on flexibility, recognizing that parents and families have strengths for meeting their needs, know their needs best and should not be restricted to a pre-selected list of services. It emphasizes respect for and partnership with families and children in the planning, delivery and evaluation of services and stresses collaboration among the various agencies that serve children with the goal of enabling children to live with their families, achieve success in home, schools and community. (President's New Freedom Commission, 2002) This description of child mental health best practice is to provide clarification on these issues as they relate to children with moderate and severe emotional disturbances, and their families. Specifically, it will address:

- Elements of a comprehensive, family-centered orientation as it relates to support and service provision.
- Integration of effective mental health services for children with other agencies that serve them supported and held accountable within a system of best practice.
- Person-centered planning within a wraparound approach that addresses the ecological and developmental context of children's lives.
- Best practice services, interventions and supports that result in meaningful outcomes for children and their families.

Best Practices in Comprehensive Community-Based Support and Services

Achieving meaningful outcomes for children with mental health problems requires that services be delivered within a family-centered and comprehensive care framework. Services must be:

- **Family-centered:** A family-centered approach is embraced across disciplines and settings, recognizing the centrality of the family in the lives of their children. Family-centered services are guided by fully informed choices made by the family and focus on strengths and capabilities of these families. Family-centered care providers acknowledge that each family member influences the family as a whole. Family-centered service providers try to address all challenges that may influence children who need care, meaning that they work with other agencies to provide wrap-around care. Family-centered professionals look for the strengths of each family member and value parental knowledge and experience. (Beach Center on Disability, University of Kansas)
<http://www.beachcenter.org/frames.php3?id=55&category=Research>
- **Wraparound:** Services and supports are planned and delivered in the context of full partnership with the family through wraparound approaches in child and family teams. Community agencies, private providers, family members and advocates then work together to support child and family teams and hold each other accountable for outcomes through local community collaboratives (Burchard, J.D., Bruns, E.J., & Burchard, S.N. (2002) "The Wraparound Approach," in B. Burns & K. Hoagwood (Eds.) *Community-Based Interventions for Children and Families*. Oxford: Oxford University Press).

- **Provided across agencies:** Children needing mental health services may be identified directly by their families; however, they are often identified through one of five distinct types of service sectors: schools, juvenile justice, child welfare, general health and mental health agencies. These agencies have different mandates to serve various groups and to provide somewhat varied levels of services. Many of these agencies arose historically for another purpose, only to recognize later that mental health problems cause, contribute to or are effects of the trouble being addressed (President's New Freedom Commission, 2002 Surgeon General's Report). A comprehensive community-based mental health service system must tackle the problem of service fragmentation. Fragmentation leads to and overuse of costly and largely ineffective out of home placements. Fragmentation must be replaced by creating a coordinated network of services and supports for these children and their families (President's New Freedom Commission, 2002).
- **Culturally responsive and community connected:** A key to the success of mental health programs is how well they use and are connected with established, accepted, credible community supports. The more this is the case, the less likely families view such help as threatening and as carrying stigma; this is particularly true for families who are members of racial and ethnic minority groups (Bentelspacher et al., 1994). Mental health programs attempting to serve diverse populations must incorporate an understanding of culture, traditions, beliefs, and culture-specific family interactions into their design (Dasen et al., 1988) and form working partnerships with communities in order to become successful (Kretzman & McKnight, 1993). Ultimately, the solution offered by professionals and the process of problem resolution or treatment should be consistent with, or at least tolerable to, the natural supportive environments that reflect clients' values and help-seeking behaviors (Lee, 1996).
- **Be outcomes accountable:** Evidence-based clinical interventions are integrated with family supports into a comprehensive plan of care that is individualized for each child and family and that change over time to ensure a goodness of fit. Clinical interventions must be held accountable by functional outcomes that measure a child's success for the child and family at home and school/work and in the community.

Family-Centered Wraparound Approaches as a Unifying Model

The Division requires a family approach to support children and their families. This approach recognizes the importance of the family system and the fact that the services and supports will have an impact on the entire family system. Therefore, the focus of the person-centered planning process is the child/family and recognizes that family members are integral to the development and implementation of the plan. The literature indicates wraparound as best practice for children with serious emotional disturbance and/or substance abuse and their families.

Wraparound is a team approach to children's mental health services that has evolved over the past 15 years through efforts to help families with the most challenging children function more effectively in the community. It was conceived as and is intended to be an alternative to institutionalization and as a response to growing concerns about the ineffectiveness of overly restrictive, categorical mental health and special education services for children with emotional and

behavioral disabilities. More specifically, it is a definable family-centered planning process that results in a unique set of community services and natural supports that are individualized for a child and family in the home, school and community environments to achieve a positive set of outcomes. Rather than being limited by the traditional placements usually offered (i.e., residential, special school, self-contained classroom), the wraparound approach allows providers and families to create individualized plans drawing from people and resources built across the various segments of systems. Supports are built into natural environments – nontraditional providers such as parent partners, student buddies, neighbors, faith-based organizations and volunteers are often part of a wraparound plan for a child and family. Wraparound approaches are universally recognized as identified as best practice in children’s mental health (President’s New Freedom Commission, 2002, Surgeon General’s Report, 1999).

The service structures and practice principles listed below provide the framework necessary for implementation of wraparound – standards of care in services and supports that will help meet the family’s needs and the structures within which services and supports are implemented. Operating simultaneously, they provide the primary active ingredients for outcomes-accountable, comprehensive care and treatment:

- Each child and family presents a unique combination of strengths and needs.
- Effective programs build on those strengths as they provide assistance to children and families, respecting culture and family preferences.
- Under wraparound every response will be different, because every child and family is different.
- Each plan of care should reflect and support those differences.
- Providers must be able to identify the functional strengths presented by children and families even when those children and families are experiencing serious problems in their lives. In addition, providers must be able to modify their service options in order to respond quickly and appropriately to the changing needs of each child and family. Furthermore, when children and families have complex needs and are open to several human service systems at the same time, providers must be able to work collaboratively with other individuals and agencies.
- Children and families should have one plan and one team, regardless of the complexity of their needs.

Service and Support Structures

Children with mental health needs and their families need flexible, community-based services that are managed and coordinated as an organized and collaborative service system:

- **Comprehensive plans of care through child and family teams:** Children and their families receive mental health services and supports through child and family teams (one family/one team/one plan), using person-centered and wraparound approaches. Comprehensive plans of care are authorized through the family’s child and family team, regardless of where the child is residing.

- **Local decision-making and shared accountability:** Community collaboratives with broad representation across agencies/providers, families and community manage the overall wraparound process and establish the local vision and mission. Collaboratives provide shared leadership, support, responsibility and accountability for implementation of their community's service system. Participants are intricately involved in the development and implementation of their child and family teams and provider network and help ensure quality standards for care and outcomes.

- **Service array and access:** Children and their families have access to an accessible and comprehensive array of mental health/behavioral services, sufficient to ensure that they receive the treatment they need. A lead organization or a network of organizations delivering services is accountable to the community collaborative structure, which manages the implementation of the wraparound process. The array of services includes those provided in family's homes, in their children's schools and in other community locations as needed by the family. Treatment or resource coordinators assist the family, through their child and family team to access services and supports. Mental health services are adapted or created when they are needed but not available. The community collaborative structure reviews the plans.

- **Connection to natural/social supports:** The child and family team with assistance from the community collaborative identifies, promotes and appropriately utilizes natural supports available from the child and parents' own network of associates including friends and neighbors and from community organizations such as service and religious organizations.

- **Assessment:** Evidence based intervention begins with timely and accurate assessment of mental health needs using psychometrically valid and culturally instruments. Assessment instruments paint a picture of a child and family at a given moment in time. Whenever possible agencies doing assessment should try to get information from earlier assessments done by other agencies in order to get an accurate picture of the child.

Standards of Care

- **Collaboration with the child and family:** Respect for and active collaboration with the child and parents is the cornerstone to achieving meaningful outcomes. Families must be full and active partners in every level of the wraparound process. Parents and children are treated as partners in the assessment process, and the planning, delivery and evaluation of services and their preferences are taken seriously. Services include support and training for parents in meeting their child's mental health needs and support and training for children in self-management. Comprehensive plans of care identify parents' and children's need for training and support to participate as partners in the assessment process and in the planning, delivery and evaluation of services and provide that such training and support, including advance discussions and help with understanding written materials.

- **Functional outcomes:** Outcomes must be determined and measured for the system, for the program and for the individual child and family. Services and supports must be individualized, built on strengths and meet the needs of children and families across life domains to promote success, safety and permanence in home, school and community.

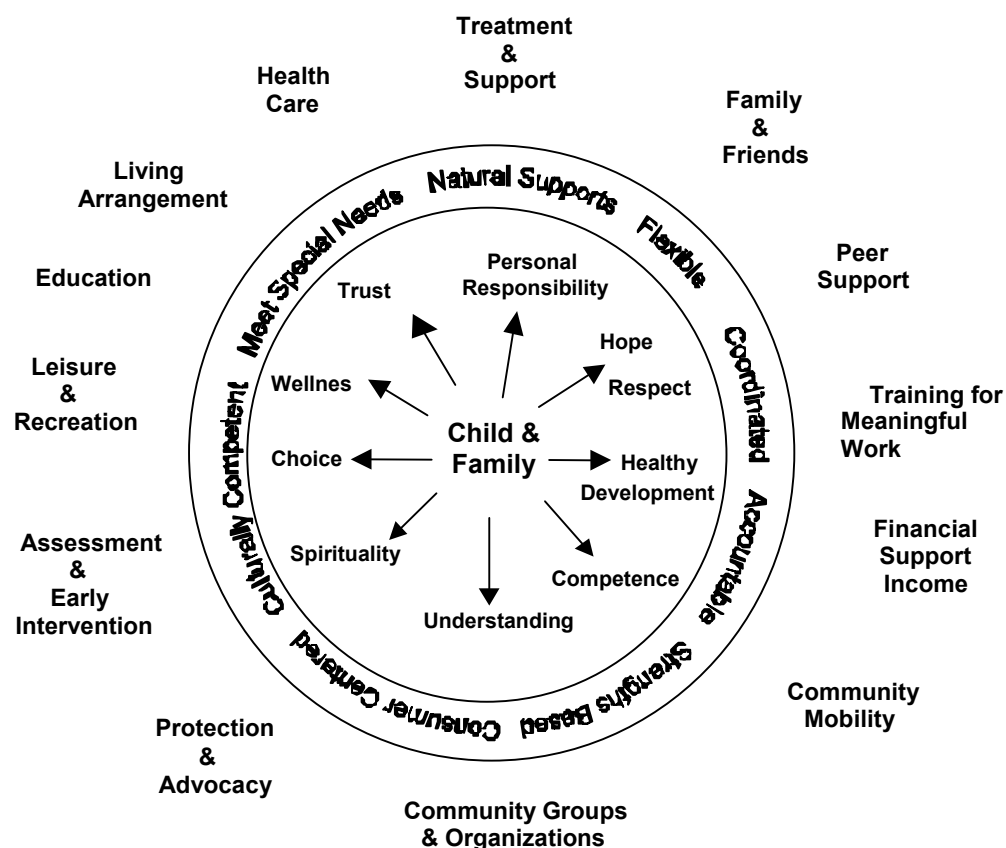
Services are designed and implemented to aid children to live with their families or in the most family-like setting, achieve success in school, avoid delinquency and become stable and productive adults. Implementation of a comprehensive plan of care stabilizes the child's condition and addresses any safety risks. Psychometrically valid and culturally sensitive assessment instruments should measure outcomes.

- **Collaboration with others:** The wraparound approach must be a team-driven process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualized plan. When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established plan of care is collaboratively implemented. Family-centered child and family teams plan and deliver services. Each child and family team includes the child and parents or caretaker, and any individual important in the child's life that is invited to participate by the child or parents. The team is lead by the parent/caretaker and a treatment/resource coordinator who is responsible to the team for planning, implementation and monitoring. The team includes any other persons needed to develop an effective plan, including, as appropriate, representatives from government agencies and the schools. The team (a) develops a common assessment of the child and family's strengths and needs, (b) develops a comprehensive plan of care, (c) monitors implementation of the plan and (d) makes adjustments in the plan if it is not succeeding.
- **Best practices:** Mental health services must be provided by competent individuals who are adequately trained and supervised, incorporate evidence-based interventions and are held accountable to provide services within best practices. There must be an unconditional commitment to serve children and their families. Comprehensive plans of care are continuously evaluated and modified to achieving outcomes, rather than ejecting the child or family from care or moving the child to multiple out of home placements.
- **Services tailored to the child and family:** Child and family teams must have flexible approaches and adequate and flexible funding to ensure that the unique strengths and needs of children and their families dictate the type, mix and intensity of services provided. Comprehensive plans of care reflect a balance of formal services and informal community and family supports. Services and supports must be individualized, built on strengths and meet the needs of children and families across life domains to promote success, safety, and permanence in home, school and community. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking and what services they think are required to meet these goals.
- **Stability:** Child and family teams strive to keep the child with his/her family, in his/her school and community. If a child is at risk of placement out of home, comprehensive plans of care identify steps to be taken to minimize or eliminate the risk. Child and family teams anticipate safety concerns or crises that might develop and include specific strategies and services that will be employed to address them. In responding to safety concerns or crises, all appropriate services will be used to help the child remain at home, minimize placement disruptions (if the child is already placed out of the home) and avoid the inappropriate use of law enforcement or the criminal justice system. Out of home placements for children with mental health needs are a last resort, used only for safety and treatment purposes that

relate directly to measurable outcomes, with concrete plans to bring them back to a stable/permanent home, their schools and community.

- **Transitions:** Comprehensive plans of care anticipate and appropriately plan for transitions in children's and their family's lives, including transitions out of wraparound services as well as transitions to new schools and transitions to adult services.
- **Respect for the child and family's unique cultural heritage:** The process must be culturally competent, building on the unique values, preferences and strengths of children and families and their communities. Mental health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.

The illustration below shows the way in which the concept of wraparound for children with mental health/behavioral needs and their families is essential to implementing reforms that are consistent with the State Plan vision and principles.



Best Practice Supports and Services

There is remarkable consensus around best practice supports and services for children with mental health and behavioral problems and their families. Those best practice services that have empirical evidence of efficacy are considered to be evidence-based practice. A recent publication by Barbara Burns and Kimberly Hoagwood, *Community Treatment for Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders*, provides an overview and details. The Center for Mental Health Services, through annual reports on the National Evaluation to Congress and through their *Promising Practices for Systems of Care* monograph series, describes current and emerging research supporting best practices for children and their families. Additional best practice information is provided in the Surgeon General's Call to Action report on Child Mental Health and through reports of the President's New Freedom Commission. There is consensus across these publications that is reflected in this document.

It is the intent of the Division that the services identified through these documents are a priority. LMEs should utilize these materials for training and in the development of services, supports and integrated systems and utilize associated evaluation tools through the LMEs quality improvement responsibility to ensure fidelity to the model of service throughout the provider network.

The following breaks out the type of service and support array that should be available to children in an integrated service delivery system. The array is divided into three categories based on the role that the LME/mental health providers/Division of MH/DD/SAS has in this integrated system.

Things Mental Health Manages/Does	Things Mental Health Does in Collaboration with Others	Things Mental Health Promotes, Connects to and or Supports
Case management	School-based mental health services	Education, including early childhood
Intensive home-based family interventions	Integrated crisis response	Legal services
Community psychiatry	Positive behavioral intervention and supports (and school based wrap-around)	Protection and advocacy
Social skills/problem solving training	Integrated family support	Recreational activity
Respite care	Independent living supports	Family support and advocacy
Assessment for behavior health needs	Assessment for educational and family functioning	EPSDT and other early childhood health assessments
	Vocational counseling	Peer support and advocacy
	Multi-dimensional treatment foster care	Tutoring
	Early child hood screening	Nurse home visit/ wellness programs
	Treatment courts	Health services

	DSS – multiple response system	Respite cooperatives
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A list of best practices for the services in which mental health carries the primary responsibility or directly collaborates is listed on the following pages. Essential elements of a best practice service are listed as well as characteristics of individuals who benefit most from this particular service.

DIMENSION: CASE MANAGEMENT

Case Management

- **Essential Elements**
 - Children and families are linked with all services, benefits and entitlements for which they qualify and that they choose to receive.
 - Case manager participates in and/or leads child and family team planning process with other child serving agencies and stakeholders to develop comprehensive, integrated, family-centered plan.
 - Case manager helps with application process and advocates for entitlements, if child or family experiences a barrier to service or entitlement access, and monitors ongoing connection between child/family and entitlement/service.
 - Case manager also partners with family/child to help connect with natural community supports and resources.
 - Case manager to child ratio is maintained at approximately 1: 12-15.
 - Case management is provided within the context of a partnership relationship; the case manager provides support and problem-solving assistance, as needed.
 - Case management occurs through community-based (rather than office based) contacts.
 - 24/7 crisis response capacity for individuals being provided case management services.
- **Who Benefits**
 - Children with serious emotional disturbances with multiple and/ or complex needs and their families/caregivers.

DIMENSION: MENTAL HEALTH TREATMENT

Intensive Home-Based Family Interventions

- **Essential Elements**
 - Child and family centered strength based mental health interventions emphasizing aggressively managed individualized treatment through person centered planning and delivered in the home.
 - Works with child in context of family to promote real life skills development.
 - Team includes Masters prepared clinician as therapist and case manager and paraprofessional(s) providing one-on-one implementation of the PCP.
 - Clinician specific interventions include: assessment, person centered planning, intensive case management, crisis planning, support, family education, individual and family counseling, life skills development, advocacy, monitoring of support and services purchased.

- 24/365 crisis intervention and management response directly provided by the home based case manager and Para-professional.
- Strengthens connections to informal community resources and natural supports rather than supplanting with Para/professional interventions.
- Interventions may include: all accepted and outcomes-based mental health approaches for children with serious emotional disturbances such as cognitive-behavioral, applied behavioral analysis, family systems, trauma therapy, and coordination with community psychiatry.
- For Substance involved youth, SA assessment and development of dynamic treatment plan.
- For Juvenile Justice involved youth and those with serious anti-social behavior, multi-systemic therapy may be used in the context of the home-based intervention.
- For multi-system involved youth the wraparound approach outlined in this document would apply.
- For children birth to 5 years old with attachment disorder appropriate attachment disorder treatment would be delivered.
- Includes a transition to independence process system (TIPS) to prepare youth and young adults to move into adult roles.
- **Who Benefits**
 - Youth with serious emotional disturbances but especially those with severely inappropriate behavior, with multi-system involvement, and at risk for out of home placement.
 - And for whom there is at least one family member/caregiver who is willing to participate in home based services.

Community Psychiatry

- **Essential Elements**
 - Psychiatrist works as part of multidisciplinary team in a community based program to meet the needs of child consumers.
 - Collaborates with public agencies, consumer groups and family organizations.
 - Understands and works with patients within their sociocultural context and strives for optimal enhancement of functioning and recovery.
 - Strong public education role and is source of expertise to colleagues, providers, community, consumers, and families.
 - Participates in development, implementation and support of comprehensive network of mental health services for children.
- **Who Benefits**
 - All children and families served by mental health system.

Assessment for Behavioral Health Needs

- **Essential Elements**
 - Strengths-based tool (for example BERS).
 - Integrated when possible with person/family centered planning process.
 - Looks across life domains and is based on life/family history.
 - Functional assessment approach.

- **Who Benefits**
 - All children seeking mental health services.
 - All children receiving mental health services.
 - Agencies learn how well clients are responding to treatment.

DIMENSION: MENTAL HEALTH INTERVENTIONS DELIVERED IN COLLABORATION

Early Childhood Screening (with Public Health, Medical Community)

- **Essential Elements**
 - Children are screened early to prevent developmental and medical problems.
- **Who Benefits**
 - All children seeking mental health services.
 - All children receiving mental health services.

Positive Behavioral Intervention and Supports (with Schools)

- **Essential Elements**
 - Integrates school wide assessment of problem behaviors.
 - Use of behavioral science to institute practical functional based behavioral and academic interventions with all children.
 - While focused on reinforcing positive behavior in all children, PBIS directs more school-based supports from existing school personnel to those who need some additional intervention. Identifies the small number of children who need outside expertise including wraparound services.
 - Individualized support planning.
 - Team-based planning and problem solving.
 - Proactive, outcome driven perspectives.
- **Who Benefits**
 - All school aged children, but especially those with mild behavioral problems.
 - Children with more challenging behavior or at risk for problems.
 - School personnel get a systematic way to access formal mental health services for their most challenging students.

Treatment/Specialty Courts (with Court System)

- **Essential Elements**
 - Integrates family court, juvenile justice and child protective services hearings so decisions about same child are not made discretely from one another.
 - Case management that ensures that a single judge is responsible for all cases involving a given family and judge has access to all appropriate court and other records.
 - Mental health needs seen in context rather than as separate issue.
 - Judge able to remove barriers to cross-agency collaboration that facilitates data sharing, blended funding and cross training.

- Client monitoring is consistent as jurisdiction is maintained over case until resolution.
- **Who Benefits**
 - Children and families with multiple systems involvement.
 - Court personnel get better access to information about clients.
 - DSS, MH and justice personnel answer to one judge on each case.

Multi-dimensional Treatment foster Care (with DSS)

- **Essential Elements**
 - Foster families are recruited, trained, supervised and supported to provide youth with close supervision, fair and consistent limits, predictable consequences and a supportive relationship with an adult.
 - Youth participate in weekly therapy to assist in adjustment.
 - Main treatment effect is expected to occur in the MTFC. PCP/FCP outcome domains are closely monitored.
 - Youth participate in a structured daily behavior management program that outlines activities and expectations.
 - Foster parents have daily phone contact and weekly meetings with support provider/case manager.
 - Family therapy is provided for youth's biological or adoptive families with a focus on problem solving and communication skills, de-escalating family conflict, advocacy training and methods of structured supervision in the MTFC home.
- **Who Benefits**
 - Children and Families for whom intensive home based treatment is not an option at that point, especially those with chronic anti-social behavior, severe emotional disturbance and delinquency.

Multiple Response System (with DSS)

- **Essential Elements**
 - Approaches child protective services through community child protection strategies which apply family support and family centered service principles while not compromising child safety.
 - Allows for more than one type of response to initial reports of child maltreatment.
 - Focused on family centered and strength based assessment and planning process rather than incident-focuses investigative processes alone.
 - When child's safety is not in question, stabilization of family is emphasized to enable parents to better care for children.
 - Child and family team approach used to develop plan of care and service delivery.
- **Who Benefits**
 - Children and Families reported for child maltreatment/neglect.
 - Case managers able to emphasize family strengthening, service delivery and connection to resources.

Assessment for Educational and Family Functioning

- **Essential Elements**
 - Strengths-based.
 - Integrated when possible with person/family centered planning process and other assessment processes through child serving agencies.
 - Functional assessment approach.
- **Who Benefits**
 - All children seeking mental health services.
 - All children receiving mental health services.

DIMENSION: CRISIS RESPONSE SYSTEM

Integrated Crisis Response System

- **Essential Elements**
 - Crisis plans.
 - Crisis services and hospital diversion.
 - Crisis respite.
 - Community Policing Mental Health (Charlotte pilot program).
 - School-based crisis response.
- **Who Benefits**
 - Community Crisis personnel (MH, DSS, EMT, police, Fire, hospital, etc) are involved, trained and prepared to handle child mental health situations in context of system of care principles.
 - Individuals who experience a mental health crisis.

DIMENSION: REHABILITATION SERVICES

Vocational Counseling and Independent Living Supports

- **Essential Elements**
 - Begins with middle school aged child and continues through transition to independence.
 - Establishing a partnership between service provider and consumer.
 - Helping the consumer choose a role and setting in which s/he would like to live, learn or work.
 - Identifying the skills and resources needed to be successful.
 - Helping the consumer learn the skills needed to reach goals & linking the person with the support/resources needed for success.
 - Can be done individually or in groups.
 - Should occur over several months.
- **Who Benefits**

- Individuals with severe emotional disturbances with interest in employment, independent living, and/or education.

Social Skills Training

- **Essential Elements**
 - Is not a “stand alone” service, as it co-exists within the comprehensive case management models of practice (e.g. Intensive In-Home, MST and Community Support Team).
 - Training is based on a documented curriculum that is developed by the Child and Family Team and utilized as a strategy in the PCP.
 - Utilizes a curriculum, which is a task analysis, typically a social task analysis intended to teach a specific skill or set of skills such as good decision making, relationship between cause and effect, how to make friends and be a friend, how not to get kicked off the football team, etc.
 - Is individualized for each youth served.
 - Modeling, role playing, positive and corrective feedback, homework use social learning principles to teach social skills.
 - Involves multiple weekly sessions to implement the individualized curriculum and is evaluated regularly for achievement of the intended outcomes.
 - The individual responsible for implementing the curriculum participates in the PCP process.
 - Individual and group formats.
 - Training lasts 3 months to over a year as long as intended outcomes are being achieved.
 - Training occurs in client’s natural setting.
- **Who Benefits**
 - Individuals with schizophrenia who have poor social functioning.

DIMENSION: FAMILY AND COMMUNITY SUPPORT

Integrated Family Support

- **Essential Elements**
 - Services are provided in the context of partnership with family and natural community supports and include things like:
 - Family to family support.
 - Health services.
 - Independent living support.
 - Respite care.
 - Intensive home based counseling.
 - Peer and family support groups.
 - Advocacy training and support.
 - Psycho-social education.
 - Services are integrated with DSS, Courts, DJJDP, Schools and other stakeholders where possible.

- Match parents with trained/experienced peers while also providing education/technical assistance and support in group setting.
- Key element of psychoeducation is its focus: must be on expectations and common goal setting, social and clinical needs, education needs, communication needs, family strengths and weaknesses, stress-reduction, problem-solving, coping, crisis plans, skills training, and other support.
- Oriented to future, not to past.
- **Who Benefits**
 - Children and families with time and resource intensive needs: emotional support, case management, financial assistance, advocacy, housing, etc.

Respite Care

- **Essential Elements**
 - Temporary care for children with disabilities.
 - Trained providers offer relief and much needed breaks for full-time caregivers.
 - May be provided in the home, or in a group setting such as a group home, childcare center or a residential center.
 - Care is in partnership with family that includes clear expectations and guidelines.
 - Respite care is not a substitute for appropriate social and community interaction or regular child care services.
 - Respite provider is trained to provide care including skills for emergencies, but need not be professional.
- **Who Benefits**
 - Children who are at risk for out-of-home placement.
 - Families who face the possibility of having to place a child in an out-of-home setting.

DIMENSION: PEER SUPPORT

Peer Support

- **Essential Elements**
 - Child Peer Consumers share support, hope, skills and problem solving strategies with other consumers.
 - Voluntary and consumer run, with guidance of consumer/family organizations.
- **Who Benefits**
 - Children connect with others around recovery and have opportunity to share their experiences and helping others.
 - Research has shown that members of mutual support groups report increased hope and self-understanding, longer community tenure, increased social integration.

Other Critical Areas

The following areas should also be provided particular attention as part of the supports and services for children with serious emotional disturbances or severe and persistent mental illness.

- **Psychiatric inpatient:** Best practice models include alternatives to episodes of inpatient psychiatric care. Individuals may require psychiatric hospitalizations. It is imperative that the process of discharge planning initiate with the admission. This includes efforts intended on maintaining resources in the community to prepare for the person's discharge (continued family support and counseling, as a key example). Furthermore, the discharge itself should be a planned effort that ensures community supports and services are in place so the individual may connect with needed services immediately upon discharge. The person-centered plan crisis contingency component should address episodes of inpatient psychiatric care – from admission to discharge.
- **Brief out of home placements:** Best practice models such as wraparound services act as alternatives to treating children in residential settings. There are situations in which treatment while remaining in the home is not possible and may require placement in a residential treatment facility. Other community and home based models of treatment delivery should be explored first, guided by a “no-eject no-reject” philosophy. Out-of home placement should be planned to only be as long as needed to reach safety and treatment goals and should be delivered in the least restrictive setting. As with hospitalization, it is imperative that the process of planning for return to the home (or for some children a foster home/adoption placement situation) initiate with the admission. This includes efforts intended on maintaining resources in the community to prepare for the person's return (continued family support and counseling, as a key example). Furthermore, the return itself should be a planned effort that ensures community supports and services are in place so the individual may connect with needed services immediately upon leaving the residential facility.
- **Monitoring of medications:** When medications are indicated as part of the treatment plan consumers and families should have access to quality assessment and diagnosis, appropriate algorithm use and consumer/family psycho-social and or medication education, so that families/consumers can advocate well with medical personnel regarding their medications.

Developmental Disabilities – Best Practice

We acknowledge that there are competing discussions in the developmental disabilities community regarding the identification of best practice models. Although the foundations of best practice are well recognized in the concepts of self-determination and person-centered planning, there continues to be debate around specific models of best practice across the spectrum of life domains, as well as the methodologies and data used to support these models. Elements of effectiveness have been identified and are beginning to be incorporated into emerging models. In light of this continuing discussion, specific models of best practice have yet to be identified within the State Plan. During SFY 03-04 the Division will work with stakeholders at the national, state and community levels to more clearly identify specific models and practices in all life domains.

State Plan 2003 has defined best practice in the interim as those supports and services experienced by the individual with developmental disabilities as being “responsive and effective.” New methods will need to be developed to evaluate the effectiveness of the strategies we use to support individuals. Traditional quality assurance methods have often focused on the process rather than the outcome.

This section is presented in two sequential components: the foundations for all practice and a description of the best practice models. Best practice programs, services and supports are well implemented, scientifically defensible, supported by formal evaluation and research, have documented evidence of significant consensus among experts in the field, and have demonstrated effectiveness and positive outcomes for consumers and their families.

Foundation: Self-determination

Self-determination is not a program, it is a philosophy and set of principles to guide and constrain practice. Self-determination should be the vision of supporting the lives of all individuals with developmental disabilities. The consensus four principles of self-determination are as follows (Nerney, T., *The Poverty of Human Services: An Introduction*. The Self-Determination National Program Office of the Institute of Disability, University of New Hampshire. July, 1998; pp. 5-6).

- **Freedom to develop a personal life plan** – The work of those committed to persons with disabilities is simply to assist in operationalizing freedom for those who may need assistance in exercising this basic American right.
- **Authority to control a targeted sum of resources** – Systems committed to persons with disabilities have to first isolate the dollars available, no matter whether capitation strategies are utilized, and insist that the dollars be under the control of the individuals and freely chosen family and friends. This means the dollars are also free. They can be re-configured, priorities can be changed, and the dollars can follow the individual.
- **Support to obtain personal goals** – Those caring individuals who are committed to individuals with disabilities have to also be free to provide assistance both within and without existing systems to achieve the type and intensity of supports that an individual may desire.
- **Responsibility for contributing to one's community and using public dollars wisely** – Individuals with disabilities and those close to them have the ordinary obligation associated with freedom in America. These are obligations of citizenship and include the obligation to spend public dollars in ways that are life enhancing and cost-effective. This obligation includes engaging other social, business and religion organizations in ways that help redefine and build community for all of us.

Best Practice Supports and Services

While acknowledging that a system will always seek to organize itself around programs and activities, best practice for providing services and supports to persons who experience developmental disabilities is person/family-centered and focuses on the goals and outcomes identified by the person with the disability. In any field, best practices are those activities that are responsive and effective, particularly in the experience of the individual. This means that their use must be based on a track record of success and that their value must be clearly evident through research. As their use becomes standardized, other pockets of excellence may arise and be considered best practice. There should always be tension between the standard of care and emerging best practices.

There are a number of elements or features in the overlapping disciplines and fields involved in services and supports for persons who experience disabilities that serve to define a best practice. While not all-inclusive, the following elements/characteristics are apparent in the field of services and supports for people with disabilities:

- **Person/Family Centered:** responsive to the “customers” of the system.
- **Array of Options Exist:** choices exist among both paid and natural supports.
- **Informed Choice:** based on knowledge/experience of person/family.
- **Balance of Supports and Needs/Interests:** “no more and no less” than needed.
- **Periodic Evaluation:** to determine effectiveness and improve delivery of supports.
- **Objective:** free of conflicts of interest in the determination of supports and services.
- **Competent Staff:** trained and knowledgeable staff, with strong supportive values.
- **Aggressively Integrative/Inclusive:** in provision of supports, e.g. living arrangements, employment, volunteer, educational, leisure, health, etc.
- **Culturally Competent/Sensitive:** responsive to the values and traditions of those served.
- **Monitoring and Evaluation Practices:** exceed health and safety requirements and are concerned with the total life situation of the individual and/or family.
- **Flexible System:** accommodates and actively supports (challenges itself) best practice.

The State Plan requires that services to target populations reflect best practice. The State Plan also requires that services be provided and developed within a self-determination orientation. Services, in and of themselves, or any specific constellation of services, do not define best practice for people who experience developmental disabilities. Rather, services are merely strategies to assist the person in attaining the goals and outcomes he or she individually identifies as important and desirable within the span and continuum of an array of life domains.

For example within the developmental disabilities community, life domain groupings and names may vary. Regardless of the labels, domains focus around where people live, work, recreate, secure health care and secure educational/habilitative services. Some examples of ways that the DD community may structure life domains to be utilized in a person-centered system include:

- Access to habilitation and education.
- Community connections.
- Health and wellness.
- Recreation and leisure.
- Meaningful work and roles in life.
- Safe and secure environments.

Within each of the domains, dimensions and quality of life enhancement techniques are required. (Source: Robert L. Schalock, "A Quest for Quality," *Quality Performance in Human Services*, Gardner and Nudler) Dimensions include:

- Emotional well being.
- Interpersonal relationships.
- Material well being.
- Personal development.
- Physical well being.
- Self-determination.
- Social Inclusion.

Each dimension needs to include exemplary enhancement techniques. Examples include increasing safety, allowing for spirituality, allowing for intimacy, allowing ownership, encouraging proper nutrition and promoting positive social roles.

Strategies are the methods that are intended to promote the achievement of the outcomes. Often strategies are gathered up and become programs. Programs are not best practice, but how we organize our resources. Strategies that reflect the highest standards of care presently available in the system may or may not be best practice. The goal of the system is to take pockets of excellence considered the best practice known at the time and raise these best practices to the standard of care.

Substance Abuse – Best Practice

This section is presented as a process initiating with the foundations of practice and building to the best practice models. Best practice programs, services and supports are well implemented, scientifically defensible, supported by formal evaluation and research, have documented evidence of significant consensus among experts in the field, and have demonstrated effectiveness and positive outcomes for consumers and their families.

Foundation: Recovery

Recovery is a philosophical framework for substance abuse that recognizes and accepts chronic disability as part of the person's life-long experience. A recovery-oriented model presumes that individuals can learn to effectively manage their symptoms, maximize their level of functioning and go on to attain a life of meaning, productivity and satisfaction. For substance abuse, the recovery philosophy emphasis is on development of the individual's coping mechanisms and self-esteem primarily derived from learning, self-help, peer support and pursuit of valued life roles. The recovery concept is at the heart of effective substance abuse services and an integral foundation of the state system reform. The Division embraces a broad vision of recovery that involves a process of restoring or developing a positive and meaningful sense of identity apart from one's condition and rebuilding a life despite or within limitations imposed by that condition.

The best practice for a recovery oriented system identifies and builds upon an individual's assets, strengths and areas of health and competence that supports a sense of achievement and mastery over his or her condition while regaining a meaningful, constructive sense of membership in the broader community. The recovery process is not simple or linear. It is a life long process of change and growth that is frequently marked by periods or episodes of relapse. Recovery is a multileveled, complex, developmental process of change at behavioral, cognitive, psychodynamic, systems and spiritual levels. As SAMHSA's Workgroup on Substance Abuse Self-Help Organizations states, "there are a variety of pathways to recovery and providers should have a menu of treatment and self-help group options available for use when selecting care in consultation with the consumer and other stakeholders."

The State Plan requires that services to target populations reflect best practice. Best practice for substance abuse services is built on the core philosophies of recovery and person-centeredness. These philosophies emphasize services that are client influenced and driven and produce real life outcomes. Additionally, community substance abuse services must be grounded in the framework of the National Treatment Plan developed by the Center for Substance Abuse Treatment (CSAT). Further, they must follow guidelines published by the National Institute of Alcohol Abuse and Alcoholism (NIAAA) and the evidence-based requirements for effective substance abuse services published by the National Institute of Drug Abuse (NIDA).

The specific language of person-centered planning has not been traditionally part of the lexicon of substance abuse services; therefore, the description provided here is intended to build upon the description provided at the beginning of this chapter. However, person-centered planning and thinking has always been central to recovery. Recovery from addiction has always focused not

only on the symptoms of and treatment for the disease of addiction, but also on the individual's life that is to be restored. This restoration of an individual's physical mental and cognitive functioning, as well as the restoration of the individual's family, social network, community engagement and spiritual life has always been central to best practice in substance abuse services.

The Division has now adopted person-centered planning as a foundation for substance abuse best practice. The adoption of this philosophy will help formalize as part of the best practice system core beliefs, processes and outcomes that support an individual's recovery and empower the consumer to identify and reach their own real life outcomes. In addition, any best practice person-centered planning process contains certain core components. Motivational Enhancement Therapy is showing promise as an important strategy for all substance abuse target populations and empowers the consumer to identify their own issues and motivation for change.

Clinical Protocols

The information that follows does not address the specific clinical protocols for substance abuse practice for programs funded by the North Carolina Division of MH/DD/SA services. Those specific clinical protocols can be found in a companion series entitled *North Carolina Clinical Guidelines Series V.: Treatment of Substance Abuse Related Disorders*, September 2003. LMEs will be required to arrange for each American Society of Addiction Medicine (ASAM) level of services to be available within their network. LMEs will be expected to demonstrate a diligent attempt to design, develop and contract for substance abuse services that meet evidence based best practices for each of the substance abuse target populations. The North Carolina Modified ASAM Patient Placement Criteria is the framework for the levels of care and patient placement process adopted under the reform efforts for substance abuse services (see appendix D).

Principles of Effective Substance Abuse Service

Using The National Institute of Drug Abuse's (NIDA) core principles of best practice for effective substance abuse services as a guide, North Carolina has outlined the following guidelines for effective services in the LME networks:

No single treatment service is appropriate for all individuals.

North Carolina's public substance abuse treatment system must have every level of care within each community network of services. Appropriate matching of addiction severity to intensity of treatment services by utilization of NC Modified Patient Placement Criteria (see appendix D) will insure successful treatment outcomes. Treatment services should be delivered in the least restrictive setting and most clinically appropriate setting possible. The networks are responsible for insuring that a repertoire of services exists which will allow treatment response to be tailored to the recipient's unique needs and life situations insuring that service responsiveness is person centered not program centered.

Treatment needs to be readily available.

North Carolina's State Plan 2002: State Strategic Business Plan outlines access standards for the system and expectations of the local network services. Additionally, treatment services to each consumer must be seamless without waiting lists or gaps between services particularly when the consumer is shifted between levels of care or referred to different providers.

Effective treatment attends to the multiple needs of the individual, not just his or her alcohol and drug use.

North Carolina has endorsed the use of a statistically valid and reliable assessment tool that will conduct a multi-dimensional assessment, history and diagnosis of addiction. The assessment and treatment planning processes will include the significant collaterals in the consumer's life. LMEs are expected to develop complete continuums of care inclusive of a comprehensive array of supports such as housing and transportation, childcare, legal assistance, education and vocational assistance, medical and financial (Refer to the earlier segment on Integrated System of Recovery Oriented Services and Supports). Additionally, services and programs should be ethnically, culturally, socio-economically sensitive and gender specific. The staff will be skilled and competent.

An individual's treatment and recovery plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.

North Carolina has adopted the principles of person-centered planning that speak to regular ongoing negotiation with the consumer, continuous monitoring and assessment and insuring that the plan is a dynamic in nature addressing the changing needs of the consumer, their family and their situation. For substance abuse treatment to be most effective and responsive to the changing needs of the recovery environment, relapse prevention must be addressed within every level of care.

Remaining in treatment an adequate period of time is critical for treatment effectiveness and successful recovery.

Effective treatment principles in North Carolina will include treatment plan goals being accomplished prior to discharge.

Counseling (individual and group) and other behavioral therapies are critical components of effective treatment for addiction.

Substance abuse treatment plans for consumers in North Carolina will reflect individual and group counseling as well as other behavioral therapies.

Medications are an important element of treatment for many individuals, especially when combined with counseling and other behavioral therapies.

Treatment records will document that every recipient of substance abuse treatment services in North Carolina will have been evaluated for the use of appropriate medication concurrent with behavior assisted therapies.

Addicted or drug-abusing individuals with co-existing mental disorders should have both disorders treated in an integrated manner.

Effective treatment of co-occurring disorders in North Carolina will include evidence that screening, assessment, treatment planning and delivery of services include co-occurring disorders and where present; treatment services will be integrated in a coordinated and effective fashion.

Medical detoxification is only the first stage of addiction treatment and by itself, does little to change long-term alcohol and drug use.

Effective treatment for addiction is a process and not a singular event or service. Detoxification represents the initial beginning of the recovery process. It is crucial that LMEs, provider organizations, and clinicians employ extraordinary measures to insure that referrals for subsequent levels of care occur without a gap in time or waiting period for service delivery.

Individuals who enter treatment under legal pressure have outcomes as favorable as those who enter treatment voluntarily.

Outreach to effectively engage consumers are imperative, particularly for those who are involuntary admissions. The local TASC staff is to be involved in coordinating plans and services for those consumers who have involvement in the criminal justice system within North Carolina.

Possible alcohol and drug use during treatment must be monitored continuously and interventions timely for treatment to be effective and recovery to occur.

Programs and services will use bio-medical measures to empower the consumer to monitor progress in their recovery.

Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, tuberculosis, and other infectious diseases, and provide counseling, and case management services to help clients modify or change behaviors that place themselves or others at risk of infection.

LME's and Providers will insure that all admissions will be provided assessment for all of the above listed contagious and infectious diseases and provide appropriate and effective counseling and community support services to assist consumers in modifying their unhealthy behaviors to minimize or eliminate risk factors.

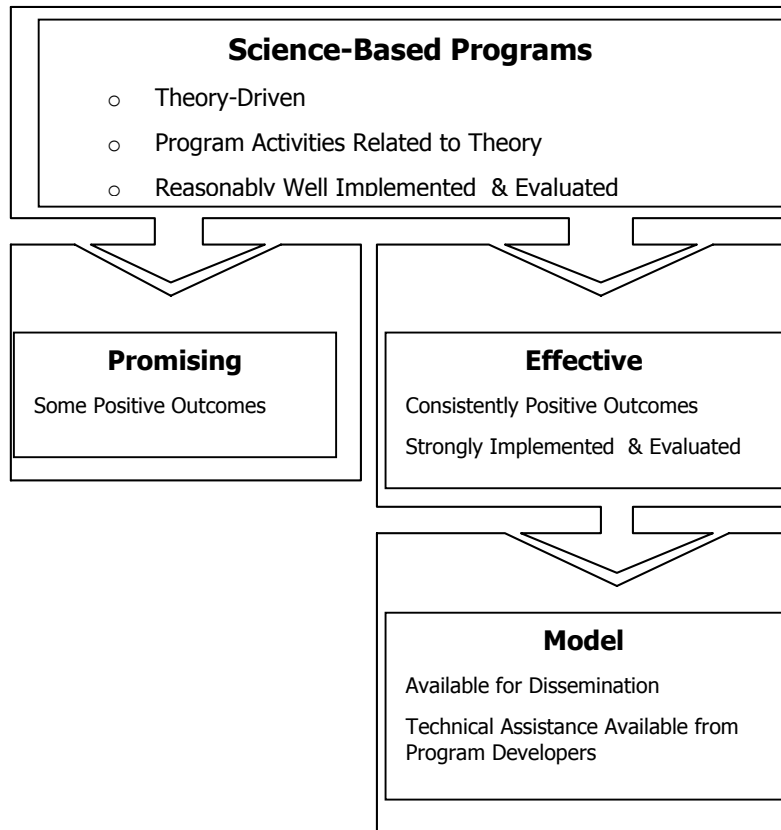
Early and ongoing recovery from alcohol and drug addiction can be a long-term process and frequently requires multiple episodes of treatment to be effective.

In North Carolina, relapse does not preclude readmission. Relapse patterns need to be evaluated and considered when utilizing the NC Patient Placement Criteria. Consumers who experience frequent relapse cycles need to be considered for placement to more intensive levels of care and are not to be excluded from admission to services.

What is a Best Practice?

In SAMHSA's Model Programs Manual, *Science-Based Prevention Programs and Principles*, 2002, best practice principles are outlined in the following manner. The strength of science and the scientific method is that it uses strictly defined, standardized procedures to determine how events are causally related. As science improves its methods, levels of certainty about the nature of cause-and-effect relationships increase and more is understood about the resources and effort to achieve specific changes in existing relationships. Using the scientific method more systematically to identify the knowledge also fosters recognition of the diversity of approaches involved in implementing programs and extracting data.

The reform of the substance abuse treatment system in North Carolina will employ those treatment elements, models, programs and therapies that have demonstrated evidence for promising and effective best practices within the substance abuse treatment research and literature.



Target Populations and Best Practice Supports and Services

This section provides information regarding the various target populations and best practices.

Target Population: Substance Abuse Prevention, Indicated and Selected

Substance abuse prevention best practice elements, models/programs/therapies is to be released in January 2004.

Target Population: Injecting drug users, those with communicable disease and/or those enrolled in opioid treatment programs

- **Best Practice Elements**

- Screening and assessment for co-existing disorders and communicable diseases.
- Integrated treatment of HIV and substance abuse issues.
- Inclusion of pharmacological and non-pharmacological treatment modalities to include individual, group, family therapy and support groups.
- Provision or linkage to social services to include: case management, housing, home health care, respite care, transportation, legal and advocacy services.
- Self help group attendance.
- Inclusion of non-clinical activities to include: Alcoholics and Narcotics Anonymous meetings, spiritual development, stress management, and relaxation techniques.
- Inclusion of the family and other collateral supports are essential to the effectiveness of the treatment effort.

- **Evidence-Based Models /Programs/Therapies**

- Cognitive Behavioral Treatment (CBT) cognitive-behavioral therapy (based on social learning theory and designed to provide skills for avoiding relapse. Activities include role-playing, active discussion, workbooks and, exercises relevant to the population. Ancillary treatment includes social skill development, cognitive processing, anger management, problem-solving techniques, and pre-vocational and vocational training.
- Medication Assisted Treatment (Methadone, LAAM, Buprenorphine).
- Motivational Enhancement Therapy (MET) based on motivational psychology and designed to help the consumer mobilize personal resources to effect change.
- Twelve-Step Facilitation Therapy based on the principles of Alcoholics Anonymous but an independent treatment designed to familiarize patients with the AA philosophy and to encourage participation.

Target Population: Substance abusing women with children and DSS-involved parents who are substance abusers

- **Best Practice Elements**

- Use of state mandated assessment tool e.g. SUDDS IV. (Note for Work First Women target population, SUDDS IV is required.)
- Offer gender-specific services that respond to women's needs regarding reproductive health, sexuality, relationships, and all forms of victimization. Services should be offered in a nonjudgmental manner and in a supportive environment.
- Addresses links between addictive disorders and causal factors and consequences within the confines of the program including:
 - Sexual abuse.

- Domestic violence.
- Depression.
- Suicidal ideation and attempt.
- HIV risk factors and behaviors.
- Family history of addictive behaviors, particularly parental substance abuse.
- Insure primary, follow-up, and early intervention pediatric care for women's children including immunizations.
- Provide therapeutic interventions for children in custody of women in treatment including such things as developmental screening.
- Provide transportation services, including cab vouchers, bus tokens, and alternatives for women who live in communities where public transportation is cumbersome, or unreliable.
- Offer childcare, baby-sitting, and therapeutic day care services for women accessing treatment and medical services.
- Insure provision or referral of primary medical care for women receiving treatment services.
- Conduct counseling services, including individual, group, and family therapy.
- Offer vocational and educational services leading to training for meaningful employment.
- Intensive community support/case management services a critical element in gender specific services.
- Self help group attendance.
- Provide age appropriate services that recognize the unique needs of adolescent substance-users who are pregnant.
- Provide integrated trauma treatment with evidence-based model.
- **Evidence-Based Models/Programs/Therapies**
 - Trauma Recovery and Empowerment (TREM) This intervention, developed by Maxine Harris, covers 33 topics to be addressed in the process of recovery from trauma. Each topic is presented with a clinical rationale, a set of goals, a series of questions to be posed to the group and an experiential exercise.
 - Seeking Safety, developed by Lisa Najavits, Ph.D., is a highly structured intervention with evenly divided domains, which addresses a behavioral skill relevant to co-occurring disorders.
 - CASAWORKS, a model intervention designed for mothers receiving public assistance with substance abuse and addiction problems to help them become employed, sober and safe responsible parents.
- **Promising Models/Programs/Therapies**
 - Behavioral Marital Therapy engages family members to support the consumers' recovery efforts. Spouses are engaged in marital therapy, triggers for using are identified and efforts are made to improve communication and address areas of conflict.

Marital therapy has been shown to reduce treatment drop out and to improve marital relationships.

- Cognitive Behavioral Treatment (CBT) cognitive-behavioral therapy (based on social learning theory and designed to provide skills for avoiding relapse. Activities include role-playing, active discussion, workbooks and, exercises relevant to the population. Ancillary treatment includes social skill development, cognitive processing, anger management, problem-solving techniques, and pre-vocational and vocational training.
- Community Reinforcement Approach (CRA, CRA + Vouchers) Functional analysis, social and recreational counseling, employment counseling, drug refusal training, relaxation training, behavioral skills training, and reciprocal relationship counseling are the main components of CRA strategies. The addition of vouchers (contingency management) to the CRA model was done to reinforce abstinence.
- Dialectical Behavior Therapy (DBT) is a comprehensive cognitive-behavioral treatment for complex, difficult-to-treat mental disorders.
- Motivational Enhancement Therapy (MET) based on motivational psychology and designed to help the consumer mobilize personal resources to effect change. Recommended as an engagement strategy for substance abusing women.
- The Relational Model developed by the Stone Center for Developmental Studies at Wellesley College the Self-In-Relation model offers a comprehensive, coordinated, family-centered or relational approach.

Target Population: Children and Adolescents with Primary Substance-Related Disorders

▪ **Best Practice Elements**

- Treatment interventions tailored for adolescent engagement in ranges of developmental maturity. Adolescent treatment environments at every level of care within the continuum need to accommodate the differences in the adolescent developmental and attentional capacities.
- Placement of adolescent consumer based upon the NC Modified ASAM criteria.
- A complete continuum of care for adolescents is optimum or extremely close and coordinated linkages with a variety of levels of care. Movement of the adolescent between levels of care needs to occur as seamlessly as possible. Ideally, continuity of the counselor will be maintained throughout the treatment experience.
- Family involvement offered within every level of care within the continuum is essential.
- Clinical staff whose competencies demonstrate expertise in adolescent substance abuse treatment modalities.
- A network of community resources and strategies for effectively integrating treatment for those adolescents with dually diagnosed conditions.
- Individual and home base services indicated for juvenile justice involved children.
- Group counseling is contraindicated for juvenile justice involved children.

▪ **Evidence-Based Models/ Therapies/Programs**

- Brief Strategic Family Therapy (BSFT) is a family-based, problem-focused substance abuse and behavior problem treatment and prevention intervention targeted toward children aged 6-17.
- Cannabis Youth Treatment Project (CYT) is targeted toward adolescent cannabis users between the ages of 12-18. It incorporates motivational enhancement therapy (MET) and cognitive behavioral therapy (CBT) as individually- and group-administered forms of treatment. It also includes Multidimensional Family Therapy and the Family Support Network and an Adolescent Community Reinforcement Approach.
- Cognitive Behavioral Therapy (CBT) cognitive-behavioral therapy (based on social learning theory and designed to provide skills for avoiding relapse. Activities include role-playing, active discussion, workbooks and, exercises relevant to the population. Ancillary treatment includes social skill development, cognitive processing, anger management, problem-solving techniques, and pre-vocational and vocational training designed for juvenile justice children.
- Multi-dimensional Family Therapy (MDFT) is a family-based, empirically supported form of treatment targeted toward adolescents, aged 11-18 with drug and behavior problems.
- Multi-systemic Therapy (MST) is an intensive, family-oriented, home-based treatment program targeted toward juvenile offenders aged 12-17 who exhibit problems of both substance abuse and chronic violence.
- **Promising Models/Programs/Therapies**
 - Managing Access to Juvenile Offender Resources and Services (MAJORS)
 - Motivational Enhancement Therapy (MET) based on motivational psychology and designed to help the consumer mobilize personal resources to effect change.

Target Population: Substance Abusing Adults Involved in the Criminal Justice System

- **Best Practice Elements**
 - Demonstrated partnerships between criminal justice (including courts, the judiciary, probation services, law enforcement, District Attorneys' offices, local BAR associations and Public Defenders' offices) and treatment systems. Utilizing the leverage of criminal justice requirements to engage and retain clients, with a therapeutic emphasis on motivating change in unwanted behavior. The partnership must be evidenced by local memoranda of agreement, cooperative agreements, routine meetings, collegial relationships, shared decision-making, etc.
 - The goal of reduced recidivism rates (probation violations, re-arrests, convictions, returns to prison) must be a shared goal of the criminal justice and treatment systems.
 - Screening, assessment and intake procedures must be in place to allow offender-clients to move quickly into treatment. Waiting lists for offender-clients are unacceptable. Programs must capitalize on the leverage provided by the justice system to employ this engagement strategy.
 - Treatment programs and services should operate according to detailed curricula that outline treatment activities, objectives & strategies. Activities should be intensive and behavioral in nature.

- Programs should target specific criminogenic needs (crime-producing behaviors). Eighty percent of any program's activities must target the behaviors that result in violations of the law. This may require specialized programs in some instances (e.g. sex offender treatment, anger management).
- The overall monitoring & structuring offender-client time is essential. Forty to 70 percent of an offender's time should be occupied. This may include treatment, community-based services, work, school, etc.
- Adequate treatment duration and intensity are critical for lasting change. This element varies by offender risk. Nine-twelve months of engagement in structured activities, including continuing care, are optimal.
- Clearly delineated program rules and sanctions for non-compliant behaviors must be discussed with and acknowledged by the offender-client. Any non-compliant behavior must be addressed from a strengths-based perspective with an eye towards both public safety and person-centered treatment plan goals. Use of behavioral contracting to clearly establish behavioral expectations.
- The appropriate use of rewards & punishments is vital. The ratio of rewards to punishments must be four to one, respectively. Actions within a program must target anti-social behaviors, by seeking to extinguish anti-social behaviors, while emphasizing pro-social behaviors, i.e. rewarding positive behaviors exponentially increases positive behavior, compared to the efforts of sanctioning of negative behaviors.
- Responsiveness, treatment and service matching are critical components of offender-specific behavioral healthcare. A variety of options along a continuum of care are critical to successful individual outcomes and public safety. Offenders, staff and programs must be matched based on risk to public safety, offender-client needs, learning styles, teaching styles, accessibility and personal preferences.
- A continuity of care must be maintained and supported during transitions (from community-to-prison & prison-to-community). That continuity includes a comprehensive, sequenced variety of interventions to address barriers faced by offender-clients, including education, housing, employment, treatment, self-help, and other essential support services.
- Service providers must "reach in" to the institution - drug treatment and other critical support service providers must engage the offender-client several months before release. Release planning must be coordinated between both the institution and community-based service providers.
- Urinalyses should be used judiciously and should be coordinated with justice system testing throughout program stays to identify needs for modifications to treatment plans or adjustments to levels of care.
- Training, modeling and reinforcement of pro-social behaviors is effective. Attempts to directly reduce negative behaviors are less effective. This element should be considered with regard to staff engagement capabilities that include staff-to-client therapeutic alliances with respect for justice system requirements.
- Engagement & retention strategies should also be employed with family and significant others to ensure a support structure for the offender-clients' success in the community. Family and significant others must be educated to be supportive. Mere orientation is inadequate.

- Programs must establish clearly defined completion criteria that are incorporated in the person-centered plan.
- Booster sessions, aftercare & continuing care must be provided. The application of ideas and positive, pro-social habits learned in treatment must be sustained. Sessions must reflect the offender-clients' person-centered plan, their progress in the level and modality of care in which they participated. It is inappropriate for an offender-client to "start-over" based on system difficulties relating to transitions.
- Performance evaluation capability is necessary for continued funding and to manage program improvement. Evaluation must include processes, outcomes and costs analysis to improve individual offender-client outcomes.
- More intensive treatment should be reserved for high-risk offender-clients. They respond better to intensive services, while low risk offender-clients do as well or better with minimal intervention. Residential treatment must be reserved for those offenders exhibiting the most severe addiction problems, and not used to temporarily warehouse "problem" offender-clients.
- Targeting of specific criminogenic needs treatment for specific types of crimes (e.g. sex offender, violence).
- **Evidence-Based Models/Programs/Therapies**
 - Cognitive Behavioral Therapy (CBT) – based on social learning theory and designed to provide skills for avoiding relapse. Activities include role-playing, active discussion, workbooks and, exercises relevant to the population. Ancillary treatment includes social skill development, cognitive processing, anger management, problem-solving techniques, and pre-vocational and vocational training. One type of CBT programs is Moral Reconation Therapy (MRT), which focuses on moral reasoning and development. MRT has been demonstrated to be effective in reducing recidivism in Washington state (MacKenzie, 1998).
 - Minnesota Model – includes multidisciplinary treatment team, a therapeutic community milieu, small group therapy, psycho-education, and aftercare. Although this model is traditionally a self-help approach with non-professional, recovering addicts as group leaders, it can be facilitated and delivered as a formal, curriculum-based treatment.
 - Social Learning – describes addiction as learned maladaptive behavior that can be treated by teaching and modeling pro-social behavior. This theory stresses modifying the individual's behavioral coping skills and cognitive processes to improve the ability to function in social environments (Parks et al., 1999).
 - Therapeutic Communities – the principle aim of a TC is global life-style change; including abstinence from AODs, elimination of antisocial behavior, enhanced education, constructive employment, and development of pro-social attitudes and values. All TCs include the following elements: community structure, hierarchy, and confrontation in order to rehabilitate clients (CSAT, 1995).
- **Promising Models/Programs/Therapies**
 - Treatment Accountability for Safer Communities (TASC) Services. TASC is a nationally recognized case management model for facilitating treatment for substance abusing offenders in the community. TASC case management provides structured linkages between the criminal justice and treatment systems through service coordination.

Target Population: Deaf and Hard of Hearing

▪ Best Practice Elements

- Provide an identified clinician that is sign language fluent, culturally competent and familiar with evidenced-based practices to the deaf and hard of hearing population.
- Treatment planning for the deaf individual with substance abuse issues needs to involve a member of the individual's family and/or sober support system.
- Clinical services need to be designed to accommodate individual counseling sessions as well as peer-oriented feedback, and adequate recovering role models, preferably with sensitivity to issues of the deaf and hard of hearing culture and challenges.
- Treatment activities need to accommodate a highly visible creative approach, not limited to reading and writing activities.
- Optimum placement for deaf individuals experiencing substance abuse issues includes the following:
 - Adapted therapeutic approaches.
 - Staff fluent in American Sign Language (ASL).
 - Qualified interpreters.
 - Language accessible support groups and residential placements.
 - Utilize local deaf resources.
 - Recovering deaf role models.
 - Technology supports including TTY machines and necessary staff training to utilize the equipment.
 - Assisted listening devices.
 - Decoders and/or captioned video materials.
- Use appropriate treatment model as indicated by assessment and NC Modified ASAM placement criteria.

▪ Promising Practices/Models/Therapies/Programs

- Minnesota Chemical Dependency Program for the Deaf and Hard of Hearing
<http://www.mncddeaf.org/>

Target Population: High Management Adult Substance Abusers (includes sub-populations of co-occurring and homeless individuals)

▪ High Management Best Practice Elements

- The high management substance abuse should be seen from a holistic, bio-psycho-social-spiritual perspective.
- Self-help and peer supports easily accessible and integral to the recovery process.
- Involvement of families and supportive collateral is crucial to effective treatment.

- Family education and support programs are essential for this population.
- Community Support Services play a key role in effective treatment.
- Multidisciplinary teams and approaches are necessary.
- **Co-occurring Disorders**
 - Integrated treatment of substance use and mental disorders need to be delivered by the same clinician who assumes responsibility for treating both disorders.
 - Medical education and group process are valuable elements of the treatment process.
 - Ongoing support, relapse management, and prevention are necessary strategies.
 - Understanding relapse and recovery are processes, not single events, and that relapse is not synonymous with failure is essential to successful treatment.
 - Provide multiple opportunities to learn about substance abuse treatment services so individuals can develop motivation to change.
- **Homeless Populations**
 - Conduct outreach to engage homeless people in services. Treat persons with respect and sensitivity. This is especially important in reaching persons who are disassociated from society and whom do not trust service providers.
 - Offer low-demand interventions and harm reduction strategies for those not initially willing or able to commit to sobriety. Model programs include sobering stations, safe housing for substance abusers, needle exchange programs and methadone programs.
 - Adopt a "no wrong door" policy through which individuals can access treatment from any location, any service provider, at any time.
 - Expect multiple detox and admission episodes with homeless individuals.
 - Supports to include self-help groups and community contacts.
 - Services should be provided in a convenient location according to a flexible, convenient schedule.
 - Ensure availability of a complete continuum of substance abuse treatment.
 - Provide a comprehensive array of services to address the multiple needs of homeless persons - i.e. housing, employment, counseling, etc. Integrate substance abuse treatment with mental health and primary health care. Provide case management to help homeless persons identify and access other services.
 - Provide adequate, supportive, clean and sober housing for persons recovering from addiction and affordable housing for persons exiting treatment.
 - Provide alternatives to jail for persons with substance use disorders charged with minor offenses. Provide opportunities for individuals to connect to services they need to rehabilitate.
 - Addressing physical health issues is paramount with this population.
 - Level of brain dysfunction is important to assess when intervening and designing services with this population.
- **Evidence-Based Models/Programs/Therapies**
 - Brief Therapies – e.g. solution focused, brief motivational counseling.

- Cognitive Behavioral Therapy (CBT) – based on social learning theory and designed to provide skills for avoiding relapse. Activities include role-playing, active discussion, workbooks and, exercises relevant to the population. Ancillary treatment includes social skill development, cognitive processing, anger management, problem-solving techniques
- Motivational Enhancement Therapy (MET) – based on motivational psychology and designed to help the consumer mobilize personal resources to effect change.
- Twelve-Step Facilitation Therapy – based on the principles of Alcoholics Anonymous but an independent treatment designed to familiarize patients with the AA philosophy and to encourage participation).
- Therapeutic Communities (TC) – the principle aim of a TC is global life-style change; including abstinence from AODA, elimination of antisocial behavior, enhanced education, constructive employment, and development of pro-social attitudes and values. All TCs include the following elements: community structure, hierarchy, and confrontation in order to rehabilitate clients (CSAT, 1995).
- **Promising Models/Programs/Therapies**
 - The Healing Place, Louisville, Kentucky/Raleigh, North Carolina

Target Population: DWI Offenders

- **Best Practice Elements**
 - Utilize state modified ASAM patient placement criteria to match abuse/addiction issues with ADETS program or appropriate level of care.
 - Duration of participation is the strongest predictor for reduced recidivism with the DWI population.
 - Treatment should have specific measurable goals for the offender.
 - Treatment should provide for family involvement.
 - Psycho-education is an adjunct to treatment and does not substitute for treatment services.
 - Treatment that combines strategies, such as education in conjunction with therapy and aftercare are the most effective.
 - Mechanism for status reports back to the court to help enforce compliance with the court ordered assessment and treatment.
 - Medical backup to ensure safe detoxification and healthcare, if required.
 - Based on a personalized assessment process to accurately evaluate an individual's alcohol or other drug problem. The substance abuse assessment should be conducted separately from those utilized by the courts to decrease the likelihood of offenders distorting information for their potential benefit.
 - Provided over a sufficient period of time for meaningful behavior change to occur and be monitored. A minimum of twelve months may be required when follow-up or monitoring is included as part of the treatment package.

- Not be used as a substitute for other sanctions, especially license suspensions. Treatment programs are most effective in reducing recidivism when treatment is combined with sanctions, such as license suspensions and ignition interlock requirements.
- **Evidence-Based Models/Programs/Therapies**
 - Cognitive Behavioral Treatment (CBT) cognitive-behavioral therapy (based on social learning theory and designed to provide skills for avoiding relapse. Activities include role-playing, active discussion, workbooks and, exercises relevant to the population. Ancillary treatment includes social skill development, cognitive processing, anger management, problem-solving techniques.
 - 12 Step Facilitation Therapy based on the principles of AA/NA/CA but an independent treatment designed to familiarize consumers with the self-help group's philosophy and to encourage participation.

Prevention

There is a growing body of new knowledge about effective prevention. Much of the work on prevention effectiveness comes out of extensive research on alcohol and substance abuse, but the efforts have usefulness among all disabilities. Prevention programs are reaching a new level of sophistication that includes evidence-based practices, outcome evaluations and cost/benefit considerations. In recent years, developing and delivering prevention services and programs has become a specialty in its own right. In the field of substance abuse, the prevention specialist develops a continuum of high quality prevention services consisting of:

- **Universal prevention** – targeted to populations not identified on the basis of individual risk, such as a school curriculum and healthy living skills. (See core functions.)
- **Selected prevention** – targeted to high-risk groups such as children of substance abusers.
- **Indicated prevention** – targeted to individuals with minimal but detectable signs foreshadowing substance abuse problems.

As an agency that purchases health care, the Division has an opportunity to effect change in the health status of the state by broadening the delivery system and incorporating prevention efforts alongside treatment, services and supports. Preventive interventions in physical health have been based on scientific evidence, and much has been learned about immunizations, smoking prevention and cessation, routinely covered preventive health screenings, and most recently, seat belt and helmet laws. Now there is evidence that risks also can be reduced for mental health problems, drug and alcohol abuse and physical illnesses in which onset is primarily related to behavior. By reducing risk factors and enhancing protective factors, many illnesses can be prevented or at least delayed.

As people become more informed about the effectiveness of risk reduction strategies for prevention of many mental health, developmental disability and substance abuse problems, they are more likely to demand these services. For example, individuals in recovery from alcoholism and drug addiction or those with some types of depressive disorders, may want preventive services for their children who are at high risk for similar disorders. Engaging individuals by offering

a menu of activities known to promote health and wellness can increase their knowledge and involvement in making decisions to seek out and apply prescribed interventions.

The science regarding risk and protection is large, changes rapidly and varies across disabilities. Prevention programs need to build their activities on a base of evidence sufficient to justify mounting preventive interventions.

Examples from CSAT and the national Mental Health Association of the best prospects for obtaining measurable outcomes are:

- “Prevention of initial onset of unipolar depression across the life span.
- Prevention of low birth weight and child maltreatment from birth to two years in children whose mothers are identified as being high risks.
- Prevention of alcohol or drug use by children who have an alcohol or drug abusing parent.
- Prevention of mental health problems in physically ill patients.
- Prevention of conduct disorders in young children.
- Prevention of fetal alcohol syndrome in subsequent pregnancies.”

Patricia J. Mrazek, *Preventing Mental Health and Substance Abuse Problems in Managed Care Settings*.

Chapter 4: Local Systems Supporting and Serving our Citizens and Communities

Resources are organized into a system intended to support and serve our citizens. These resources include a local public entity -- a local management entity (LME) that is responsible for leading and managing the community system. Other organizations and individuals constitute the system providers of supports and services. The manager and providers that make up this system are referred to jointly as the "specialty system." Also, naturally occurring community resources provide opportunities for people with disabilities to fully enjoy full community citizenship. These resources include religious, civic and social organizations as well as other public partners. The community resources taken together with the specialty system are referred to as the "community system."

At the local level, the manager and provider specialty system is composed of public entities, private non-profit agencies and private for-profit firms as well as individual practitioners. Each of these organizations and individuals form a collective relational enterprise that constitutes a community system for supporting and serving our citizens. Each of these organizations and individuals are committed to the values inherent in the collective nature of the community system. This includes a dedication to the key characteristics of the community system as well as the leadership role of consumers and family members, particularly as related to their formal efforts as members of the local consumer and family advisory committees (CFACs).

Key Systems Characteristics

All participant systems actors – as organizations and individuals – are expected to advance the concepts of cultural proficiency, consumerism, community and public accountability.

Cultural Proficiency

Culturally proficient systems acknowledge and respect the scope and breadth of diversity that characterizes contemporary society. People who identify themselves with a particular ethnic, cultural or religious grouping have established cultural norms or practices such as customs, language, symbolism, rituals and social or behavioral expectations. Cultural competence means that these cultural norms are recognized, accommodated and respected. Culturally competent systems, both management and provider, acknowledge and demonstrate appreciation and respect for human diversity.

Consumer Driven

This concept is often referred to as consumerism or consumer empowerment. The intention is to promote systems of support and/or services that are controlled by people with disabilities. Some models of practice may involve shared control, such as that in a psychosocial clubhouse, while

others, such as drop-in centers or consumer cooperatives, are controlled solely by people with disabilities. Some models like Alcoholics Anonymous, Schizophrenics Anonymous and peer relationship and support building are defined solely as support-oriented.

Opportunities for people with disabilities to take active participatory or leadership roles in public and private systems is a hallmark of consumer driven systems. This includes assuring that individuals are supported and accommodated, provided skill and knowledge acquisition opportunities related to their roles and responsibilities and compensated and/or recognized for their efforts.

Consumer Friendly

Customer friendly systems pay attention to issues that affect actual consumer experiences with systems of service. These issues include concerns with ease of access, staff attitudes, accommodations made for physical and other disabilities and communication throughout all aspects of all systems – from the point of entry to the point of exit. This practice requires that management and provider systems alike operate in a manner that promotes a user friendly, responsive customer service orientation in all aspects of support, services, care and treatment.

Community Benefit

The intended beneficiaries of public policy are people with disabilities, their families and communities. All other actors in this arena – managers and providers – are residual beneficiaries. Residual beneficiaries are rewarded economically as a result of supporting and serving the intended beneficiaries.

The concept of people with disabilities and their families as intended beneficiaries is easily understood. The concept of the community as an intended beneficiary is more elusive. There are seven essential aspects of the "community benefit" inherent in the public specialty system is summarized as follows:

- **Citizen Value:** People supported and served through the publicly sponsored specialty system are contributing citizens in their communities. Supporting the advancement of real life outcomes through the person-centered planning process creates opportunities for people to contribute to their communities.
- **Public Accountability:** The ultimate goal of public policy management is to both promote social justice for people with disabilities and ensure the efficient use of public resources. The leadership in the management of public policy is the responsibility of a local public entity. As a public entity, there is an expectation of operating in the "light of day." This includes responsiveness to the community and open and inviting opportunities for community participation. It is essential that the public interests be served through a local organization that is public and acts in a manner that is expected of a public entity.

- **Mission Driven Community Systems:** The system manager as well as providers of supports and services is expected to be mission driven. A "mission driven" organization is committed to advancing the quality of life of the intended beneficiaries -- people with disabilities, their families and communities. Therefore, there is no room in the system for linear self-interest driven public or private organizations. This is also a quasi-market system at best with all parties receiving public financial support, therefore the residual benefit -- profit and/or margin -- is limited and the monetary reward is directly related to expectations of effectiveness and economic efficiency.

- **Community Orientation and Collaboration:** The planning, implementation and management of the system are not limited to the active involvement of the specialty supports and services manager and providers. These efforts embrace the larger community- - other public and private systems. Embracing people with disabilities requires broad community participation. Therefore, the overall system includes the manager, provider and community.

- **Prevention Efforts:** The system is interested in community wellness. Therefore, prevention oriented efforts are intended to achieve outcomes that promote the health and wellness of the community.

- **Public Assurances:** Through the person-centered planning process, as an individual's personal safety is taken into account in the development of a support plan. This includes consideration of the proactive and reactive components of the crisis contingency plan. Along with the personal safety concerns are public safety considerations. There is a need to ensure that reasonable safeguards are in place where potential actions of particular individuals would result in a risk to public safety. In addition, unintended consequences of promoting the freedom of people with disabilities -- such as residential instability and homelessness and interactions with the criminal justice system -- are mitigated through the application of planned interventions (jail diversion programs, housing initiatives, as examples). The public manager is also accountable to the community, demonstrating the ability to develop an adequate provider network with sufficient capacity to assure prompt and easy access to services for the individual and to maintain the public safety net.

Public Accountability

The expenditure of public funds requires a commitment to the public and consumers of services for proper utilization and accountability of these funds. The state and area/county programs are accountable both to the public at large for the proper stewardship of funds and to the recipients of the supports and services purchased with public funds, to ensure that those services and supports are appropriate, cost effective **and, most importantly, result in desired outcomes**. All purchase of service contracts, financial assistance contracts or direct services through Medicaid or state support, have a commensurate accountability process -- a process of accountability on behalf of the public and service beneficiaries. Medicaid and state funded services and supports are subject to regular audit review for compliance with relevant regulations. Contracts are monitored against the terms of those contracts, as well as associated requirements of the funding sources. All audit and monitoring reports are published and are matters of public record.

System reform allows for a local and state partnership for monitoring the quality and appropriateness of mental health, developmental disabilities and substance abuse services through regular monitoring visits, review of critical incident reports, and the aggregation of statewide data for trend analysis. Staff in the Division of Mental Health, Developmental Disabilities and Substance Abuse Services are identified and tasked to perform independent complaint investigations and monitoring of all components of the mental health, developmental disabilities and substance abuse services system. This monitoring, local and state, serves to assure that the funding appropriated for mental health, developmental disabilities and substance abuse services and supports is spent appropriately, and that the consumers of mental health, developmental disabilities and substance abuse services receive the highest quality care, in the most appropriate setting, and in accordance with best practices.

Public accountability is embedded in the overall system reform process – from initial planning for service delivery and administration through the actual delivery of services, follow up, evaluation and audit.

As the system evolves, a clear and unbroken "chain of accountability" will emerge. This involves a public systems partner relationship between the leadership, support and oversight role of the state system and the management of public policy role of the local public system. In turn, the public-private systems partner relationship between the local managers of public policy and the implementers of public policy – service providers – will become evident. Additionally, the system will develop a more effective and efficient set of regulatory compliance requirements as we move to systems performance and outcomes as critical drivers of improvement efforts.

Local Consumer and Family Advisory Committees

Reform requires the establishment of a specialty system that is infused with the involvement of consumers, families, and other stakeholders. Specifically, reform charges the emerging LMEs (current area or county programs) with the responsibility of forming committees of consumers and family members, known as the consumer family advisory committees (CFACs). Although the system in North Carolina has established precedents for the involvement of consumers and families in the governance of local boards, and on function specific committees of the local public system, this reform effort seeks to broaden the involvement of consumers and families as partners in ways that are durable, sustainable, and, above all, meaningful to the development of a comprehensive system of services and supports. This partnership demands a cultural change at the local and state level. The cultural shift is evidenced by the expanded involvement of consumers in the planning process, as well as the thoughtful and deliberate, selection of consumers as staff to be employed in the fulfillment of Division and LME functions. The incorporation of consumers as employees within their own service system is a deliberate attempt to ensure that, for other consumers, the experience of navigating the various service components is consistent with the vision and principles articulated in the State Plan.

At the core of the community systems are the local consumer and family advisory committees (L-CFACs). The CFACs are comprised of individual consumers and family members representing all

disability groups. CFAC members meet on a regular basis in their communities to support and communicate their concerns, provide advice and comment on all state and local plans. They are charged with the following responsibilities:

- Offer recommendations on areas of service eligibility and service array, including identifying gaps in services.
- Assist in the identification of under-served populations.
- Provide advice and consultation regarding development of additional services and new models of service.
- Participate in monitoring service development and delivery.
- Review and comment on the state and local service budgets.
- Observe and report on the implementation of state and local business plans.
- Participate in all quality improvement measures and performance indicators.
- Ensure consumer and family participation in all quality improvement projects at both the provider and LME levels.

Although the State Plan requires the LME to “establish a consumer family advisory committee at the onset of the local planning process,” no specific guidance was given to ensure that the operational procedures and the intended outcomes were understood. This section provides guidance to the field regarding the selection of CFAC membership, as well as outlines the responsibilities of all parties during the initial phase of development prior to LME certification. It is anticipated that during the years following certification as an LME, the local CFAC will develop a greater degree of operational self-sufficiency evidenced by a significantly reduced dependence upon the support of LME staff in the areas of decision making and self-governance. The LME is expected to accommodate disabilities with supports, which may include transportation, respite care and stipends as well as information, training and mentoring as needed for the committee throughout the pre and post certification periods. The CFAC will have a budget to manage for their supports.

Area authorities or county programs, whose current practices and ongoing relationships with the CFAC are inconsistent with the intent of the guidance published here, must develop a plan of corrective action prior to any level of certification as an LME. The LME’s acknowledgement and compliance with the guidance published here should be incorporated in further developments of the strategic plan.

CFAC Guidelines

- **Governance** -- The CFAC has the right of self-governance, just as individuals have the right of self-determination, but does not have authority to make decisions or speak on behalf of the local governing entity.

- **Accountability** -- The CFAC is accountable to the governing authority, the community and constituency it serves. The CFAC is also responsible for maintaining a balance in representation of its membership.
- **Advocacy** -- The CFAC has the responsibility to represent all disability groups as well as those of different ethnic/cultural backgrounds.
- **Influence** -- The CFAC role is one of “constructive partner” with the LME in the implementation and management of public policy, as adopted by the governing authority.
- **Knowledge** -- The CFAC has an obligation to inform, to educate, and to support its membership, the state level CFAC as well as the local constituency, through its own advocacy efforts.

History: Selection of Membership

The LME is charged with the responsibility of establishing the CFAC. The selection process has been a local decision and may have been initiated by the Area Director, who solicited names from local advocacy groups, county commissioners, community groups and in some instances encouraged self nominations (consistent with criteria identified in the state plan) for submission to the governing authority. Once the selection process was complete, members were appointed often 12-15 in number.

Although the actual terms of current members vary across the state, it is the intent of this communication to direct the local governing authority to limit current terms (not current members). Current terms should coincide with the occurrence of the following events -- 90 days after the date of initial or conditional LME certification, but no later than 1/1/04. The decision to set terminal dates is designed to coincide with the development of a relational agreement leading to greater self-direction of the CFAC.

LME-Pre/Post Certification

- The Governance Board and CFAC will ensure that by-laws or operational guidelines are developed and adopted which will designate the selection and appointment process, terms of service, number of members and determine other procedural issues.
- The Board will direct management to assign staff to the committee as liaison and support.
- The LME management and CFAC will jointly prepare periodic reports to the governing board, which include the cost of operation of the committee.
- A relational agreement will be jointly developed and executed.

LME-Post Certification

The intent is for the CFAC to become a fully functioning, consumer directed committee. The roles and responsibilities of the committee are delineated in the State Plan and may be reaffirmed in the

agreement. Local agreements will dictate the type and degree of support needed by the CFAC during the post certification period. The Division shall consult with the LME and local CFAC when it is determined that the extent and duration of the support is inconsistent with the intent of the State Plan. Constructive partner means the relationship between the parties must be constructive as they share a common objective.

A copy of a "Relational Agreement" containing the essential elements of the arrangement between the LME and CFAC is provided as appendix B. The document may be amended only if the additions do not detract from these essential elements.

Local Management Entities

A local management entity (LME) is a county program or public authority that is responsible for the management of public policy for the citizens the system is intended to support and serve. The primary functions of an LME as defined in legislative and administrative planning documents are:

- General Administration and Governance.
- Business Management and Accounting.
- Information Management Analysis and Reporting.
- Provider Relations and Support.
- Access Line, Screening, Triage and Referral.
- Service Management.
 - Utilization Management and Authorization.
 - Service Coordination.
 - Care Coordination.
 - Community Collaboration.
- Consumer Affairs and Customer Services.
- Quality Improvement and Outcomes Evaluation.

General Administration and Governance

Within any administration's organizational framework are many potential dotted lines of common support between two or more units (functions, e.g., Information Systems supporting Financial Accounting; Accounting operations supporting Provider Contracting; Quality Improvement Unit jointly conducting studies with Provider Relations and Information Systems, etc.) The LME's chief executive officer (CEO) will want to look at the specialty skill sets of staff related to specific functions and balance the scope of supervisory responsibilities with logical imperatives to combine functions that share some core technologies and specific skills in order to organize the functions for which middle management is responsible.

Overall administrative responsibilities include policy development; supervision of the chain of command; responsibility for local business plan development and implementation; LME accreditation; liaison with county governance and administration; divestiture; community development; annual review and update of the strategic plan based upon the goals of the three year Local Business Plan (LBP); and stewardship of funds and resources. While Area Programs currently perform many of these functions, the focus on outcomes will be a shift toward assurance of accountability.

Business Management and Accounting

The LME responsibilities of the functions of business management and accounting are:

- Developing and managing a resource allocation and budgeting process.
- Tracking payments to providers and payments against LME budgets.
- Monitoring and re-budgeting resources to core and target populations, savings from high cost to alternative services.
- Accounting, financial management and reporting.
- Reviewing provider services budget.
- LME Personnel and training.
- Purchasing.
- Payroll.
- Managing contracts with entities other than providers in network (e.g. facility lease).

This set of responsibilities, with the mission of fiscal integrity and efficient operations, will take a much more proactive role in forecasting funds and therefore services for citizens.

Information Management Analysis and Reporting

Information management analysis and reporting is one of the most important internal systems that enable LMEs to effectively and efficiently operate. A comprehensive management information system (MIS) collects data and manages information so that the LME can operate and analyze functions in real time. Examples of information needed by an LME may include:

- Access.
- Inpatient admissions and discharges.
- Concurrent reviews.
- Appeals and grievances.
- Claims received and paid.
- The qualified provider network.
- Populations served.

- Information and referral services (access, screening, triage and referral).
- Community education and training.
- Utilization review.
- Staff activity.
- System encounters.
- Quality improvement and audits.
- Clinical data.
- Housing data.
- Ad-hoc information.

The LME will determine the potential to contract with vendors for this function or develop internal capacity for these operations.

Responsibilities would also support all telecommunications equipment needed to link client access screening, utilization management and budget management functions with the provider network. Within this function estimates were made of the efforts required to extract data and produce a number of routine management reports each month. Linking the LME to the Qualified Provider Network (QPN) through automation is a critical element to effective operations as well as enhancing the relationship with service providers.

Provider Relations and Support

One of the goals of system reform is to promote organizational cultures that improve the quality, effectiveness and efficiency of services through the adoption of best business practices for program management and operations. In a buy-sell arrangement, there is typically a need to express formal relationships and expectations between systems through formal written agreements, contracts or memoranda of agreement/understanding.

In order to ensure adequate capacity of the provider network to serve the target populations living within a LME's service area, the LME needs to determine capacity. This process involves:

- Evaluating the adequacy of its capacity and analysis of service gaps.
- Developing the provider network.
- Recruiting new providers providing services that demonstrate best practice, as needs are identified and confirmed. These providers should demonstrate real and sustainable commitment to the overall welfare of the community.

The LME will continually evaluate their network capacity. In determining the optimal size and composition of its provider network, the LME should consider the factors listed below within the context of responsible public stewardship of funds and the need to safeguard potential conflicts of interest.

- Internal evaluation of network capacity/competencies.

- Consumer/stakeholder input (obtained no less than annually via previously mentioned avenues).
- Data collection and analysis.
- Prevalence rates.
- Service utilization rates.
- Geographic distribution of the population (30/30 rule, that is within 30 miles or 30 minutes).
- Demographic characteristics and special needs of the population (ethnic distribution, age breakdown, etc.).
- Need to optimize choice of providers.
- Emergence of new treatment technologies.
- Commitment to encouraging consumer-owned and consumer operated services.

The capacity evaluation, which contains a series of recommendations regarding areas where additional providers are needed, are folded into a network development plan LMEs identified in the needs assessment and should become strategic goals for each fiscal year.

Based upon the network development plan, if there is a need for new providers to be added to the network this can be done in several ways. The network may be opened to any willing and able provider who meets standards, not requiring a Federal procurement process, or existing providers may be accredited for additional services to meet the need, also not requiring a Federal procurement process. The provider network should be developed to ensure that at least two providers are available for each type of service. Exceptions are made in the following circumstances:

- Recruiting an additional provider will entail significant overhead/fixed costs with insufficient demand to support additional costs.
- The service is so specialized that only one option exists in the service area.
- It is important to contract with a sole provider in order to maintain a single entry point for services, reduce confusion and/or streamline access.

The network development plan serves as a mechanism for analysis of the factors listed above and yields recommendations regarding the need for additional providers. This plan provides the framework for network development activities to occur over time to ensure that an optimal network is in place during each fiscal year. This plan should be reviewed and updated on an annual basis.

As the LME develops its provider network, it needs to ensure it is structured so that providers do not gain economic advantage by making referrals or care coordination decisions, therefore, certain firewalls must be established. This is especially important to consider for case management providers who may also provide other services in the network. When a case management provider seeks privileges for another service, the LME may credential them to provide this service under the

condition that they can not treat a consumer simultaneously in case management and another service.

- The LME should track referrals made by case managers and access center staff to look for/address patterns that may indicate certain providers are receiving a disproportionate share of referrals based on personal staff preferences.
- The LME should encourage the development of consumer-owned and operated services. In order to maximize the success of such endeavors, it is important to phase these services in and provide adequate supports to ensure smooth start up.
- The LME must also continuously review promising advances in clinical treatment. Assuming research has been done to demonstrate with empirical evidence the value of the approach, a decision may be made to pursue a particular clinical advance and operationalize it in the provider network.

Access Line, Screening, Triage, and Referral

Systems entry (screening, triage and referral or STR) should assure ease of access organized through the LME in order to respond to community members as quickly and accurately as possible. This system includes a brief screening function in order to determine the urgency of the situation so that the type of response is the most effective route to services. Key components and considerations of this responsibility are as follows:

- There is a statewide number, which is staffed to read electronically the caller's area code and telephone prefix and automatically route that call to the appropriate LME. Each LME operates (or may contract for) an access line that is staffed 24/7 with live, trained persons. These lines receive calls routed from the statewide server and calls made directly to local access line.
- Consumers and providers will have telephone access with a live person to respond with the ability to screen, triage, and refer. STR is available 24/7 with a live person answering the telephone, TTY for individuals who have deafness or have a hearing impairment, and with Foreign Language Interpretation capabilities.
- Primary questions for Screening, Triage, and Referral (STR) are as follows:
 - Is there a MHDDSA need or not?
 - If there is, is the need urgent, emergent, or routine?
- Consumers should not be required to undergo multiple intakes or screenings. Consumers need to get to the point of assessment and service as quickly as possible. The goal is to avoid duplications of both the screening and assessment functions.
- When a consumer presents in person at a service provider and has not been referred by the LME, the provider should contact the LME access center to secure authorization to perform an assessment. If the consumer telephones the service provider directly, the provider should link with the LME while the consumer is on the line.
- Inherent in screening is the function of referral, especially for those who have no MHDDSA need, and for those with needs that are appropriate for further assessment.
- STR is performed by trained staff that is supervised by an on-site clinician.

- One hundred percent of new consumers experience the screening function. Current consumers are not required to under go screening to continue with current service providers, until a new Person Centered Plan is developed with consumer knowing a range of choices.
- STR process is standardized, performed according to consistent statewide protocol (by script with probes for safety first, urgency, etc.). Division promulgates standards for screening (including performance standards).

Systems access efforts will result in determining if an individual is in an emergency condition or if the issues would be best categorized as urgent or routine. The responses to these types of conditions are briefly described as follows:

Callers with Emergent Needs (Crisis)

- Caller is immediately “patched” to the Crisis Response System for telephonic clinical triage. LME screener remains on the line until the crisis response system has engaged the caller.
- Crisis Response System is developed by LME and may involve several models of crisis response (e.g. on-call staff, mobile crisis team, clinic or facility based crisis screening). All components of the Crisis Response System are staffed by clinicians. Telephonic clinical triage of the problem to determine which type of crisis response is required.
- Telephonic crisis intervention counseling, as appropriate.
- Dispatch mobile crisis team, as appropriate.
- Mobilize site-based evaluation, as appropriate.
- Arrange for inpatient assessment and admission, or alternative hospital admissions placements.
- Liaise with local law enforcement in situations where needed.
- Maintain Crisis Plans on file for active consumers, including contact information for current case manager or primary clinician in the qualified provider network.
- After crisis resolution, move to the “linkage” point for on-going services and supports.

Callers with Urgent or Routines Needs

- Screening unit makes “active linkage” of caller to a service provider; schedules an appointment for a Clinical Assessment. LME screening staff makes a follow-up call with the individual to assess whether linkage occurred.
- Screening unit is a proactive response system that promotes wellness, illness self-management and support, and is responsive to consumers and families calling in effort of preventing a current situation in becoming an emergent crisis situation later on.

Service/Systems Management

Management of services and supports involves the functions of 1) utilization management and authorization, and 2) service coordination that entails both care coordination and community

collaboration. Inherent in this function is the assurance of use of best and emerging best practices identified by the state and of the dissolution of services that do not reflect such practices. Following is a description of these functions:

Utilization Management and Authorization

Utilization management (UM)/Authorization is part of the system's overall strategy for managing service use by individuals and by the system as a whole. UM/Authorization is a management function and the responsibility of the LME. This function includes: eligibility determination, medical necessity levels of care assuring each consumer gets the right amount of care and support needed (i.e., does severity of illness match the intensity of service, service and/or plan), person centered plan authorization, and utilization review. It is the management function that assures that there is a single approved Person-centered Plan (PCP) ensuring that supports in the community are identified for each service recipient.

The UM/Authorization function with respect to service planning is to ensure, through review and approval, that the PCP is coordinated, not duplicative and to assure cost effective and positive outcomes. This function also serves to ensure implementation of the plan as authorized through the review of documentation and billing/reporting data. It is not necessary for the UM/Authorization function to have a direct relationship with the individual served. UM/Authorization activities do not include those day-to-day coordination and oversight activities necessary to carry out the plan.

Service Coordination

The mental health reform statute requires that each LME include service coordination as part of the core services function. It is based upon the core functions of assessment and referral. It is also closely related to the Provider Network Development function. At the micro level, service coordination incorporates Care Coordination as it applies to individuals; at the macro level, service coordination involves Community Collaboration.

Care Coordination

Care coordination is a Service Management function and a responsibility of the LME as part of the development of the qualified provider network. Care Coordination is periodic monitoring, typically through telephone contact with service providers, of individual consumer services. Care coordination entails performing document reviews to ensure that the PCP is being implemented and data analysis of service provision. System level interaction activities help ensure the system is consumer friendly by facilitating access.

Care coordination activities include:

- Coordinating care for people who are not in the target populations, to ensure that they have been linked with generic community support service or physician for the basic benefit supports depending upon the individual's need;
- Periodically and episodically coordinating care for a subset of the people who are in the target populations, and who are not receiving case management through a private provider organization or practitioner. This would typically occur when circumstances indicate the need for assistance during an episode of more intensive care (e.g., people receiving only therapy may have the need for some care coordination, as related to episodes of inpatient care); and
- People in the target population who require brief or episodic care coordination.

Community Collaboration

Community collaboration, also a Service Management function and responsibility of the LME, addresses service delivery barriers through the following components:

- Development of a strong and seamless network of supports and services while increasing community awareness of the benefits of services.
- A mechanism to initiate and complete an assessment of community strengths and needs in regard to service and supports within the community at large, including the delivery of services and supports reflective of best practice models.
- Development of an array of services and supports throughout the community in collaboration with generic community resources, and with the LME's qualified provider network, that is responsive to identified strengths and needs of the community. This process is ongoing as the needs of the community change, and clearly addresses strategies and interventions for increasing the capacity for services and supports reflective of best practice.
- Periodic assessment of progress in completion of strategies and interventions for increasing capacity for services and supports. This includes data collection regarding service utilization and consumer and family outcomes.
- Development of a supportive relationship with consumers and families, the qualified provider network (QPN), and community partners at large to promote services and supports that are consumer driven and culturally competent.
- Collaborate with other community partners (public and private) in an effort to advance opportunities for the involvement of people with disabilities as full members of the community, to create seamless customer friendly systems of support and to partner in shared responsibilities in order to promote responsive and efficient systems.

Consumer Affairs and Customer Services

This function is designed to provide a mechanism for consumers and all citizens to register a complaint, or appeal a decision ; assist the consumer via training, addressing empowerment, advocacy; assisting the consumer advisory board; and provide assistance to recovery, self-determination, self-help and empowerment support systems. The location of this function should

be in an area that is visible and easily accessible for consumers and citizens. Following are a brief description of some of the responsibilities.

- **CFAC Support:** This function is assigned the task of staffing the CFAC of the LME. This may entail researching various issues, seeking broad consumer feedback, administering consumer satisfaction surveys, etc.
- **Consumer Complaints and Grievances:** In the area of complaints, it is important to encourage consumers and citizens to register complaints. This reduces risk for an LME, and assures increased customer satisfaction. Complaints should be handled expeditiously, with staff having the responsibility of calling the complainant back every three days, documenting the call until the issue is resolved.
- **Advocacy:** Individuals may seek assistance from Customer Affairs for the exercise of rights as well as peer support in due process. They may create venues for expression of individual concerns or support development of consumer-run initiatives (e.g. drop-in center).
- **Customer Education:** In order to ensure that customers have a clear understanding of their condition, eligibility for service, access to service, benefits, process for payment, and recipient rights/appeals, it is important that they receive current and ongoing education and information regarding behavioral health benefits, new services and opportunities for wellness.
- **Community Relations:** Promoting public awareness, decreasing the stigma of behavioral health disorders, and enhancing a positive public image by determining a) the target audience; b) the types of information to present and disseminate (i.e., type of services, diagnosis, prevention); and c) the best way to present that information to provide a positive public image, is accomplished through the education of individuals and organizations in the community on managed care benefits, services, and access.
- **Customer Relations:** Promoting an attitude and atmosphere wherein the customer is number one is accomplished through culture and environment, raising awareness and seeking feedback from customers, clinicians, payers, and the general public on methods to better meet the needs of customers and the community. One method that can be used to seek feedback is through direct evaluation of community organizations, agencies and facilities.

The program is aimed at testing the system from the standpoint of a potential consumer accessing for behavioral health services. Telephone calls are made to monitor performance by providers on: courteousness, timeliness, responsiveness, accessibility, and ability to meet their requested need or an appropriate referral to another agency.

Initially, participants should review information from the Consumer Affairs and Customer Services for trends and for recommendations. Secondly, it is reviewed by the advisory councils for recommendations. Finally, it is taken to the Quality Improvement Council for monitoring of network/ provider performance, monitoring of trends, and for identification of process improvements. If a concern is identified through the Council with a specific provider, Quality Management follows up with the provider on an individual basis for a plan of improvement. The process for setting up this type of feedback system is outlined below:

- Review current services and access system.
- Identify customers.
- Define customer service.
- Review customer complaints and questionnaires; talk with staff, board, consumers and suppliers.
- Find out what's important to customers and list customer service values/requirements and associated measures.
- Set objectives in context of continuous quality improvement plan.

Quality Improvement and Outcomes Evaluation

Continuous quality improvement (CQI), sometimes called total quality management (TQM), is the process for achieving high marks in customer satisfaction. Mental health agencies developing and implementing continuous improvement should initially train board members, leaders and managers, staff, provider agencies and consumers in the definition and evolution of quality management. This educational process includes historical information and differences between quality assurance and quality improvement, common systems for planning and reporting, objectives of CQI, elements needed to successfully implement the process, roles and responsibilities and the quality cycle.

Objectives of CQI

An integrated business model incorporates principles and practices of quality assurance, quality planning, and continuous improvement. Quality improvement processes are required to meet various accrediting body standards, often state standards, and the Center for Medicaid Services Quality Improvement Systems in Managed Care (QISMC) standards. A plan should ensure compliance with local, state, and federal law as well as regulatory and accreditation standards. An adequate CQI plan facilitates good process design, and systematically measures, assesses, and improves organizational and provider performance to produce the best consumer outcomes and satisfaction through the effective and efficient use of resources.

The scope of a CQI program is broad in that it monitors and evaluates all consumers, providers, care settings, and types of service. Participation in CQI must be a job responsibility for all board members, customers, employees, providers and other contractors. First and foremost it is critical for the agency to identify its Customers. Internal Customers are people inside your agency who depend on you for service. External Customers are people outside your agency who depend on you for service. This might include contractors, providers, community agencies, etc. Ultimate Customers are those people for whom our services exist.

The objectives of CQI are:

- Culture change.
- Increase customer satisfaction.
- Increase employee involvement.
- Eliminate rework.
- Increase efficiency.
- Improve customer/provider relations.
- Improve teamwork.
- Improve accuracy.
- Reduce cost.
- Improve functional outcomes.
- Achieve compliance with regulations, law & standards.

Elements Needed for Implementation

The four elements required for a successful CQI program are leadership commitment, structure, systems support and education and training.

There are various ways to demonstrate this commitment including providing support, being actively involved at the individual level, sustaining activity, and involving a wide range of stakeholders. Some boards have created a quality committee as part of the board committee structure. Boards and directors should publicly recognize CQI efforts and provide adequate resources to encourage participation in the program. Top leadership must embrace the effort as well and demonstrate their active interest.

The structure necessary to implement CQI includes establishing a steering committee that incorporates all stakeholders. A monitoring and evaluation structure must be implemented and should begin with goals on the strategic plan. The third criteria for an adequate structure is the creation of improvement teams when processes are identified that do not meet established benchmarks. Those individuals with a stake in the outcome should be included on the teams. Teams should be time-limited and appropriate approvals sought for final decisions through the steering committee and perhaps the board's quality committee.

Likewise, systems must be in place that allows for active participation in the CQI process. These systems include efforts to encourage employee involvement, training and practice in teamwork, frequent communication about the results of the program and recognition of efforts, solutions, savings, and improvements. Employee encouragement and recognition must occur at the highest levels of the organization. When the program becomes stale, and it will, re-energizing it will require extra effort in this area. Finally, participants need education and training in CQI tools. Those tools include strategic planning, facilitation skills, and measurement tools.

Strategic Planning

Planning at the board and leadership level begins with an environmental scan, review of previous outcomes in the context of identifying Strengths, Weaknesses, Opportunities and Threats (SWOT) to the agency and its customers. This is generally facilitated using a brainstorming process with the ultimate outcomes being consensus on a statement of values, a mission, a vision and five or six critical success factors. Goals and action steps are derived from these factors. The Statement of Values reflects how the work is conducted and how the product is delivered. The values also suggest how internal and external interactions with consumers and stakeholders should occur. The Mission of the agency establishes why the agency exists and does not change frequently unless the organization is revisiting its purpose and considering a new line of business. The Mission states what the system does, for whom, how, and where. The Vision of the agency reflects what the agency hopes to become. This generally covers a three to five year period; and the goals would be a “stretch” for the agency to attain.

Evaluation and Outcomes Monitoring

It is critical to know how important functions will be measured. What kind of reports will be made? Are there established benchmarks or are there reputable ones available through other similar agencies? To whom will information be reported? What data is currently being monitored and what does it communicate? Without answers to these questions an agency will not be able to establish a worthwhile CQI process.

Provider education and technical assistance helps providers understand how the system works. The team conducts orientation for new providers and maintains a “Provider Manual”. In some organizations, this function is carried out through a Provider Relations Team. QI staff are also available to assist providers with the development of their own CQI process, including quality improvement, data management and reporting, and compliance with standards.

The team develops and maintains a set of standards designed to assure consistent application across network providers and within the managing entity. These standards should crosswalk all state, federal, accrediting, payer, and value added local standards. Standards are reviewed annually and this team should be the sole point of contact for interpretation to promote consistency.

At least annually, the team should prepare provider profiles, wherein providers are evaluated against performance measures, utilization patterns, compliance with standards and customer satisfaction. The profiles are used for re-credentialing and contract management purposes. The profiles are made available to the general public and to consumers to assist them in making informed choices about organizations they would like to have providing services to them.

The audit, certification and accreditation coordination function assures consistent achievement of regulatory and accrediting standards. The team prepares accrediting applications and facilitates reviews. They are also responsible for the post-audit responses, plans of correction, and follow-up that are incorporated in the CQI process.

Performance measures must be evaluated across the system to capture significant trends. Performance information may be derived from audits, utilization data, demographic information, financial information, clinical record review, customer satisfaction surveys and reports from consumer and other focus groups. A system of data collection is maintained for each established indicator. Data collection is collected both concurrently and retrospectively. Sampling procedures must be established based on high risk and high volume parameters to assure randomness and representation. Key reports are pre-defined and used by the agency to make decisions and in summary format to help the organization in its annual strategic planning.

Quality process facilitation is provided across the network to achieve demonstrable and sustained improvements in care and service. The team provides technical assistance to providers. In facilitating the quality improvement team process, the team is charged with assuring that process improvement is prioritized and based upon the organization's strategic plan. They are also charged with assuring that improvements are carried out and evaluated for their value to the system. The QI team is also responsible for the support of systems teams such as the Recognition Team, the Communication Team, The Employee Involvement Team, and the Education & Training team that are necessary to support a CQI structure.

Monitoring and evaluation processes are identified by the QI team through an assessment of important organizational functions that are high volume, high risk, prone to problems, and/or critical to customer satisfaction.

Opportunities for improvement are identified through monitoring and stakeholder feedback. The recommendations for improvement are referred to the QI Council. The recommendations are prioritized based on risk factors, performance history, effect on overall network performance and consistency with the strategic plan. The committee may refer the recommendation to a standing committee that is studying an aspect of the issue or appoint a new QI team. The team is required to involve key stakeholders and that typically means consumers and at least one provider.

Some organizations use this team to perform credentialing functions to all independent practitioners and organizational providers. This includes primary source verification and a credentialing review process. In some organizations, this function is assigned to a Provider Network Team.

The QI Plan should have sub components pertaining to the committee structures:

- Risk Management Report.

- Corporate Compliance Plan.
- Credentialing Committee Report.
- Certification Review Report.
- Customer Satisfaction Plan.
- Information System/Data Integrity Report.
- Advisory Council Reports.
- Utilization Review Committee Report.
- Network Capacity and Competency Report.
- Systems Teams Reports
- Rights Report.

The leadership of the LME sets the direction and guides the process for reform. It is critical to the success of change that the governing board and staff leadership receive education and training regarding best and emerging best practices of business and service. In order for reform efforts to be successful commitment must begin at the top. During the 2002 – 2003 fiscal year, local business plans contained descriptions of area board composition. In compliance with House Bill 381, 99 percent of area programs utilized the structure set forth in 122C-118.1. Structure of area board, assuring that consumers and family members were equally represented on county/area boards. This is one example of leadership demonstrating a commitment to change.

Providers and Networks

Making sure that consumers have choices of services/supports and service providers is one of the driving forces behind the reform movement. People with disabilities need to be able to select their providers, services and supports, and also to select different ones if they find that their original choices are not satisfactory.

Choice can be looked at along two dimensions. First is the number of active providers in the network. Adequate networks will include a range of providers in each service or specialty so that people may choose from among them. In rural areas where there are very few providers, LMEs must work actively to build their networks over time. The network will be considered adequate only when opportunities for consumers and families to exercise informed choice are fully present. The option to choose is especially important when the provider works very closely with individuals on a frequent and ongoing basis. Case management and personal care services are examples. LMEs, whether they provide or contract for such services, must assure that individuals may select different people and providers if they so choose.

The second dimension of choice relates to the richness of the service and array in the regional system. Emphasis here is on a continuum of options that corresponds to the levels of service people want and need. For example, it is preferable to have a single agency that develops three

levels of supported housing/residential programs than to have three agencies that provide one single level. A person with a disability should not be forced to choose a group home when he/she is capable of living more independently. Neither should anyone be forced to opt for day activities that are static or not stimulating simply because nothing else has been developed. To provide a more robust service/support array LMEs may need to look at sharing resources and going across area/regional boundaries to enhance the availability of options. In addition, the local system must evolve in a manner in which people with disabilities, allied with others who care about them, may not only choose from among available services, but will have the opportunity to compose their own supports and services as well. The system must sustain a viable mix of services and supports. Again, developing a full array may need to take place gradually but it must be an integral part of all regional planning.

Growing out of each best practice foundation and person-centered planning is an array of integrated supports and services to support. Without this integration, including a single point of accountability, consumers will continually “fall through the cracks” of a fragmented system. This integrated service model is very distinct from a single provider practice model and in most cases closer to a multi-service agency. In some cases, all services are provided under one roof or agency (single agency model). In other cases the services needed are coordinated by a clear point of accountability through an organized comprehensive integrated community provider network system. Three types of examples of an organized system are as follows:

- **Lead arrangement:** A single provider organization is the lead entity and maintains formal relationships with a network of other provider organizations. The lead provider organization is the agency responsible for ensuring the implementation and management of the person-centered plan. As a whole, the network contains the comprehensive array of supports and services.
- **Affiliated arrangement:** A group of provider organizations formally comes together to develop a comprehensive network. This includes a range of ways to organize including the development of an administrative services organization (ASO), as an example.
- **Relational arrangement:** As part of a condition for contracting with the LME, each individual provider organization agrees to maintain a relationship with all of the other individual provider organizations in the network.

The above examples are not exhaustive. There are a variety of ways an organized system can be approached. The uniqueness of each community is the key factor considered in determining the systems configuration. In addition, the above examples are incomplete and oversimplifications.

Service definitions and provider qualifications, specified by the state, can be expected to incorporate these examples. Reimbursement mechanisms established by the State can be expected to recognize and incentivize these examples. In addition, LME provider network development responsibilities and LME responsibilities for entering into provider contracts will also reflect the specific form of the organized provider network(s) and system. The LME “network” is not in and of itself one of these examples of forms. Rather, the LME provider network is comprised of the entire panel of providers; many, if not most, will be organized in a manner similar to these examples and augmented by private practitioners, as necessary.

As LMEs proceed to divest themselves from providing direct services, they must simultaneously seek to encourage the development of new and different private provider organizations. These provider organizations must meet the characteristics consistent with the previously referenced examples. Regardless of the organized provider network system design and use, the following are the essential elements of the design:

- **Accessible:** The provider network must be organized in a manner that facilitates timely access to services and supports. Each LME will be expected to meet the standard of having services, as designated in rule, available to residents of the catchment area within 30 minutes drive time or 30 miles distance.
- **Integrated:** Each provider organization is expected to maintain relationships as part of a network responsible for delivering supports and services. The network is a constellation of provider organizations – a system. All providers that are a part of the system and receive public funds must have a formal relationship with the LME.
- **Coordinated:** All aspects of a person-centered plan are to be carried out by the provider organization in such a manner that reflects the interrelationship of each individual component of the plan.
- **Comprehensive:** A network should be comprised of a full complement of supports and services. This includes regional efforts to satisfy availability of scarce demand types of services. A system should be comprised of more than one network.
- **Community:** Each provider organization should have a viable and valued role as part of the local community and a sustainable commitment to the community.
- **Competent:** Each provider organization should demonstrate competencies as reflected through an active commitment to the foundations of a reformed system, relationships with other providers and the systems manager, exemplary application of supports and services and on-going systematic efforts of quality improvement.

Adult Mental Health

At the core of the system are the individuals or teams responsible for implementing and managing the person-centered plans; this is frequently a component of case management services. Many, but certainly not all, consumers require case management services. Many consumers with severe and persistent mental illness can benefit from blended, active, service-oriented and skill-building case management models. These services can be integrated with other services for these consumers, sometimes into a single service definition, under a reimbursement methodology that includes the case management function with payment for the other services. For example, many consumers with severe and persistent mental illness will require a form of intensive case management or will require Assertive Community Treatment (ACT).

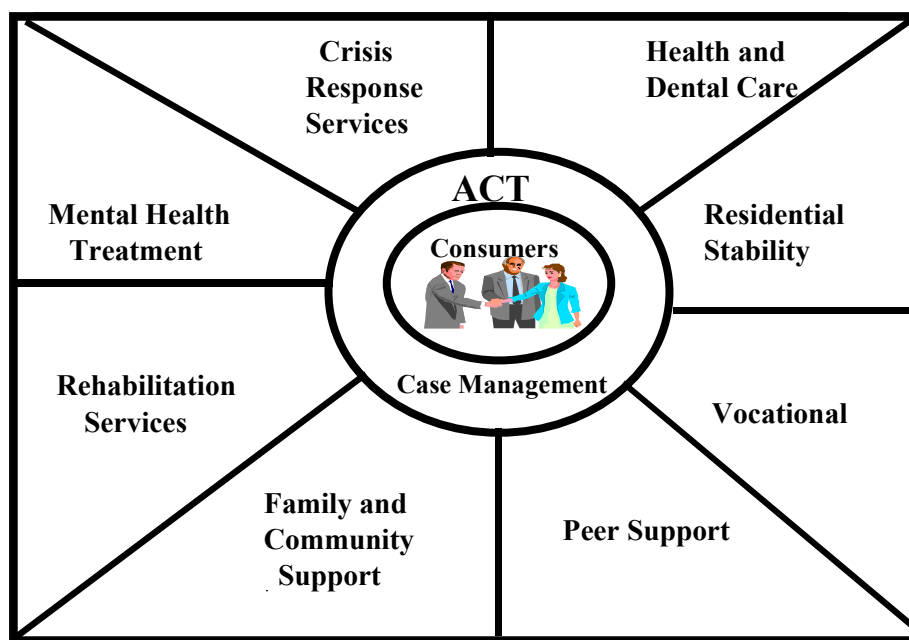
To achieve this single point of accountability and service integration, services for adults with severe and persistent mental illness are best coordinated using a single multi-service agency or multiple-agency network where the ACT team or the provider agency's case manager serves to coordinate the array of support services. The case manager is usually a member of the team. Thus, the

provider organization providing intensive case management or ACT is the ultimate accountable agency. Following required protocols (medical necessity and federal sufficiency standard, as examples), case managers and ACT teams should be empowered to make decisions and develop comprehensive treatment plans with consumers that are then submitted to the LME for approval.

The array of supports and services that are part of the organized provider network system (integrated system) fall into a number of domains:

- Mental health treatment.
- Crisis response services.
- Health and dental care.
- Housing.
- Vocational.
- Peer support.
- Family and community support.
- Rehabilitation services.

ADULT MENTAL HEALTH: INTEGRATED SYSTEM



Each dimension has a number of discrete services. These services are listed below. The Division recognizes that our current system of services does not offer all components of this array of services uniformly across the state and LMEs will not be required to offer all services in the immediate future. At the same time, the Division is working to include a number of these kinds of services in a new service taxonomy that may become eligible for federal financial participation

through Medicaid as well as state funds. This work includes clarifying service definitions, provider qualifications and reimbursement methodologies.

As Medicaid and state fund reimbursement policies are adjusted to conform to the new service definitions and as provider organizations demonstrate their capacity to provide these services, the Division expects that the local systems will include more of these providers and services. In initiating the development of the full array, there should be, at a minimum, at least one service in each dimension through their provider network (dimensions are presented in the Best Practices section of this document). This should reflect the service most consistent to the needs of the population. Continued local strategic planning should also reflect how local systems would continuously work with its provider networks to develop, over time, the array of services across dimensions.

Child Mental Health

A coordinated system of supports and services for children with behavioral and emotional disorders and their families is necessary to implement wraparound and family-centered approaches. It has long been recognized that the primary barrier to improved services for children is the lack of coordination and cooperation between child serving agencies (President's New Freedom Commission, 2002, Surgeon General's Report , 1999). Only a broad-based, community-focused service system with participation and contribution from a variety of public organizations, non-profit agencies, citizen stakeholders and parent and child advocacy organizations is needed can efficiently and effectively to respond to mental health needs of children, in the context of their families, schools, and community. A key challenge and opportunity is to break down barriers between child-serving systems and to link the reforms of the State Plan with other system reform strategies (in schools, social services and juvenile justice) to ensure a unified approach for all children with serious emotional and behavioral disturbances that is accountable to outcomes directly related to the well being of those children and families and that is consistent with national best practices (Center for Mental Health Services, National Evaluation Reports to Congress). (See President's New Freedom Commission, 2002, Surgeon General's Report, 1999.)

Better outcomes are possible for children and families when families, providers and child-serving systems work together using wraparound approaches. This can be measured by:

- Children are likely to improve in educational performance and overall social functioning.
- Fewer crimes are committed by youth involved with services.
- Residential lengths of stay are reduced.
- Children are more likely to remain in their communities.
- The number of acute psychiatric hospital re-admissions is reduced.
- Families and caretakers provide more stable living environments for children
- Children have improved emotional stability
- Families are more involved in, and better satisfied with the care their children receive

- Children are more likely to remain in their communities.
- Residential lengths of stay are reduced.
- Acute psychiatric hospital re-admissions are reduced.
- Families and caretakers provide more stable living environments for children.
- Children are likely to improve in educational performance and overall social functioning.
- Fewer crimes are committed by youth involved with services.

Each child and family presents a unique combination of strengths and needs. Therefore, to be effective, those providing assistance to children and families should build upon the specific capabilities, culture and preferences of each person. When this is done, every response will be different, because every child and family is different. Each plan of care should reflect and support those differences. Providers must be able to identify the functional strengths presented by children and families even when those children and families are experiencing serious problems in their lives. In addition, providers must be able to modify their service options in order to respond quickly and appropriately to the changing needs of each child and family. Furthermore, when children and families have complex needs and are open to several human service systems at the same time, providers must be able to work collaboratively with other individuals and agencies. Children and families should have one plan and one team, regardless of the complexity of their needs.

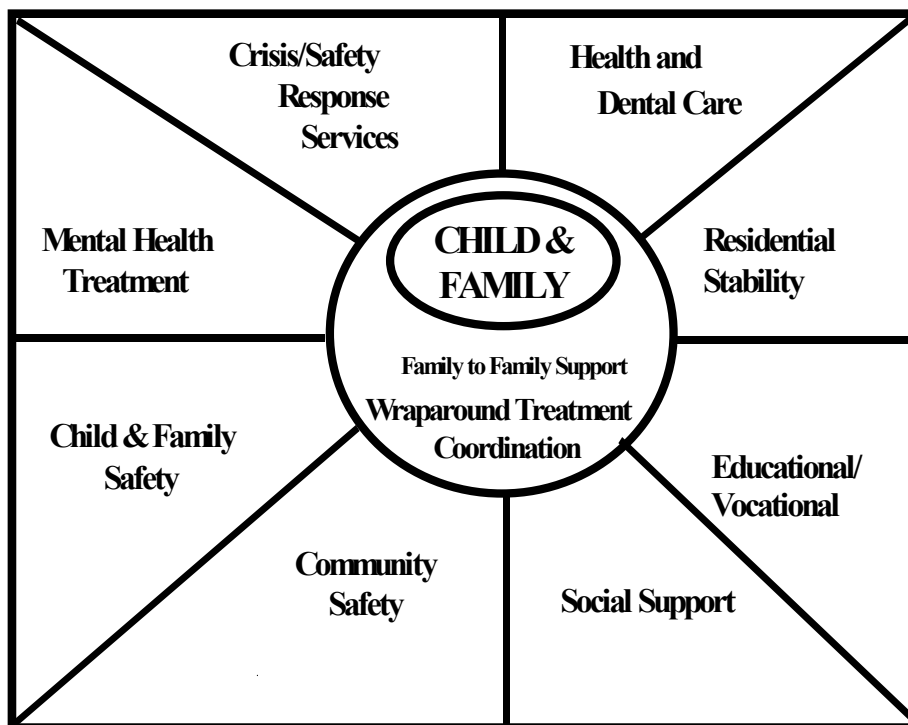
These outcomes can best be achieved by an integrated systems model. At the core of this system are the Child and Family Teams responsible for implementing and managing the family-centered wraparound plans, described previously. However, child and family teams require the active involvement and support of all the community's child serving agencies, providers and organizations. To achieve the single point of accountability needed for individual child/family outcomes and shared accountability needed for community service integration, services for children with serious emotional and behavioral needs are provided via Child and Family Teams through a multiple-agency and provider network. Each provider organization providing intensive Treatment or Resource Coordination for a given Child and Family Team is the ultimate accountable agent for individual child/family outcomes; and, each provider within the network shares accountability within the Community Collaborative. Following required protocols (e.g., medical necessity), Treatment/Resource Coordinators and Child and Family Teams should be empowered to make decisions and develop one comprehensive plan of care with the family that is then submitted to the LME, as part of the Community Collaborative, for approval. Because so many agencies, providers, and the school system are involved in the lives of children with emotional/behavioral needs, plans of care can (and should) incorporate multiple funding sources. LME approval alone is insufficient to ensure comprehensive care and avoid cost shifting.

The array of supports and services that are part of the integrated/comprehensive provider network system for children and their families fall into a number of domains:

- Family to family support.
- Mental health treatment.
- Crisis response services.

- Intensive home visitation.
- Health and dental care.
- Housing.
- Education/vocation.
- Child and family safety.
- Community safety.
- Social support.
- Neighborhood and community support.

CHILD MENTAL HEALTH: INTEGRATED SYSTEM



Each dimension has a number of discrete services. These services are listed below. The Division recognizes that our current system of services does not offer all components of this array of services uniformly across the state and LMEs will not be required to offer all services in the immediate future. Some of these services are offered by other agencies in DHHS, other Departments of state government and by private and non-profit agencies outside of government. While LMEs are not responsible for providing these services, they are expected to locate services provided by other agencies in their community and try to develop ways for clients to access these

services. At the same time, the Division is working to include a number of these kinds of services in a new service taxonomy that may become eligible for federal financial participation through Medicaid as well as state funds. This work includes clarifying service definitions, provider qualifications and reimbursement methodologies.

As the service taxonomy is developed, stakeholders will have the opportunity to have input. As Medicaid and state fund reimbursement policies are adjusted to conform to the new service definitions and as provider organizations demonstrate their capacity to provide these services, the Division expects that local systems will include more of these providers and services for children and families, working through their local Community Collaborative. This includes work the state is doing to better align funding, requirements and best practices. Local communities, however, at a minimum, offer at least one service in each dimension through their provider network. (Dimensions are presented in the Best Practices section of this document). This should reflect the service most consistent to the needs of the population. The continued local strategic planning should also reflect how the LME would continuously work with its provider networks to develop, over time, the array of services across dimensions.

Developmental Disabilities

Growing out of a self-determination orientation and person-centered planning is an array of integrated supports and services to support the individual. Without this integration, including a single point of accountability, consumers will continually “fall through the cracks” of a fragmented system.

At the core of an integrated system is the supports coordinator. The supports coordinator is part of an agency that provides supports coordination only to the particular individual. This ensures “independence” from the management entity and other systems providing a variety of supports and services. These other systems providing supports and services include traditional providers who are part of the provider network as well as non-traditional providers of supports and services. “Non-traditional” is included to be defined as individuals selected by the person with the disability to provide community supports and services, which could even include the supports coordinator. These types of relationships may be pursued through Fiscal Intermediary, Staff Leasing or Provider Systems models. The person-centered plan itself is the ultimate foundation for ensure the integration of the individuals and systems providing supports and services.

The organized provider network systems described at the onset of this chapter do not fully examine such areas as non-traditional providers. Also, because a system elects to use networking does not make it best practice. The system is not at “best practice” because it supports networks, but the system that has networks may be more likely to reflect the principles of person centered services and be outcome driven, allowing greater flexibility and choice. As in the case of best practice, while most would consider supported employment the most progressive practice, it is not in and of itself best practice. The status of a service/support strategy as “best practice” is determined by what it contributes to the consumer’s ability to achieve goals and outcomes. If a system does not achieve outcomes, it is not best practice. There are a variety of ways an organized system can be approached. The uniqueness of each community is the key factor considered in determining the systems configuration. In addition, the above examples are

incomplete and oversimplifications. An integrated system provides for means of evaluating the effectiveness of the system, including the state, local management system and providers in meeting outcomes.

Substance Abuse

The integration of services and supports to provide a system of best practice including evidence based principles of effective Substance Abuse Services and the model of comprehensive substance abuse treatment services as published by the National Institute of Drug Abuse (NIDA).

In addition to recovery and person-centered planning as the philosophical foundations for the new substance abuse system of care, there must also be a continuum of care that reflects best practice. It must be a comprehensive and integrated system of supports and services that support recovery. Without this integration, that includes a single point of accountability, consumer's will continually "fall through the cracks" of a fragmented system.

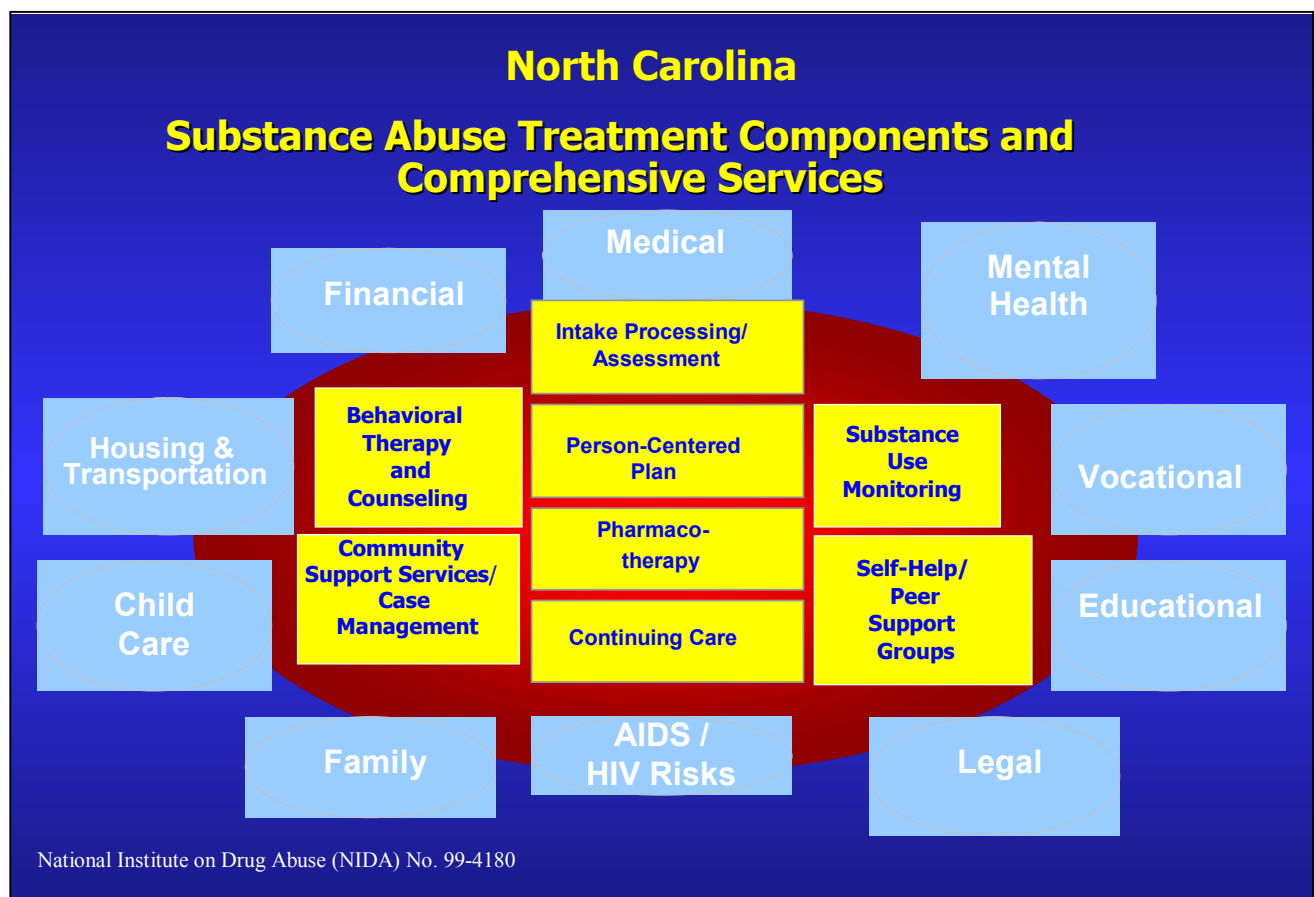
At the core of this system is the individuals or teams responsible for implementing and managing the person-centered plans; this is frequently a component of community support/case management services. Many, but certainly not all, consumers require community support/case management services. These services can be integrated with other services for these consumers. For example, many female consumers with a substance dependency diagnosis will require forms of community support services that are elements of best practice for gender specific treatment. The community support manager is usually a member of the treatment team. Following required protocols, such as medical necessity, community support managers must be able and empowered to make decisions and develop comprehensive treatment plans with consumers that are then submitted to the LME for approval.

The Center for Substance Abuse Treatment's National Treatment Plan has also identified guidelines for best practice to build a seamless system offering high quality and effective treatment. These guidelines reflect elements of the best practice service delivery system that have been integrated into the State Plan. They include:

- **Invest for results.** The wise use of resources requires investment and services that in turn must produce the desired results.
- **"No wrong door" to treatment.** Effective systems must ensure that an individual seeking services will be identified and assessed and will receive appropriate services, either directly or through referral, no matter where he or she enters the realm of services.
- **Commit to quality.** Effective treatment and services and the wise use of supports depends upon ongoing improvement in quality.
- **Change attitudes.** Significant reduction in stigma and changes in attitudes will require a concerted effort based on systematic research.
- **Build partnerships.** Effective efforts by individuals and organizations throughout the substance abuse field to work with each other and with other people and groups who share

a concern to improve substance abuse treatment will require specific encouragement and support.

Ideally, each LME will develop a comprehensive continuum of services for their constituents, the goal of which is to promote early and ongoing recovery. National Institute of Drug Abuse (NIDA) has identified an evidenced based model of comprehensive addiction treatment services which reflects the concepts of an integrated, coordinated and comprehensive community service array for substance abuse services.



Systems Development: Critical Areas of Concentration

There are many areas of systems development that is necessary for reform. In developing the Local Business Plans (LBPs), the LMEs have initiated the development of public partnerships and community and provider systems. Although concentrated efforts in all areas need to continue, housing and community hospital relationships are two areas that require increased attention.

Housing

Expanding the availability of decent, safe and affordable housing for persons with mental illness, developmental disabilities and/or substance use disorders is an area where it will be necessary to target resources – staff time, technical expertise and investment. This section provides clarification of expectations of the LMEs role in community housing efforts.

Where our constituents live is not an issue that can be addressed in isolation. It is intricately related to the work we are doing to improve our capacity to provide the depth and range of community based services necessary to support persons with serious cognitive disabilities in the community. The housing needs of MH/DD/SAS consumers, and therefore our housing efforts, must be targeted over a range of housing/residential models. The pure supportive housing model, scattered site, independent units with access to flexible support services tailored to individual needs and preferences is a recognized model of best practice. All of our housing efforts should be directed at providing consumers the opportunity to achieve maximum personal independence whether in supported living arrangements, independent living or by supporting consumers in their own homes. Within the supported housing model the clustering of independent apartments addresses the choice of many to live in proximity to others like themselves, as it maximizes opportunities for peer support and consumer direction of the housing resource. Across disability lines there is also a need for small scale structured settings, not dead end placements, but stable residential options that are designed to provide the opportunity for growth, skill building and transition to more independent living.

Under current funding and reimbursement mechanisms few of these housing options are paid for through Medicaid or Division funding. Consequently, there are few traditional providers who are willing or able to assume the housing role. Assuring availability of community housing will require that, in addition to assuring an adequate provider network, the public MH/DD/SA service system expand its capacity to support its constituents in accessing and utilizing generic affordable housing resources.

Expanding housing opportunity requires an investment of time and relationship building: first in developing connections with housing providers, both public and private, so as to maximize access to existing resources, and then parlaying these connections into new development. Housing resource development functions would include:

- Collaborating with other disability and affordable housing advocates in efforts to assure that a fair share of public resources are targeted to extremely low income persons with disabilities. This would include participating in the area's Consolidated Planning process and representing the needs of MH/DD/SAS consumers in local the Continuum of Care planning process.
- Creating an inventory of currently available housing resources accessible to consumers, families and service providers.
- Maintaining information on the unmet housing needs of persons served by the LME, prioritizing these needs and developing strategies to address them.

- Developing a positive working relationship with local Public Housing Authorities and Section 8 administrating agencies to improve access and increase the supply of these resources.
- Developing Low Income Housing Tax Credit targeting plans and then supporting the continuing relationship with development management to assure that the units remain available to MH/DD/SAS consumers and the tenants have access to appropriate services.
- Continuing administration of any current HOME or HUD Homeless Assistance grants.
- Developing and maintaining an internal wait list for consumer referrals to housing resources that have referral relationships with the LME.
- Providing local liaison to the development and operations of residential programs including Oxford Houses, 122C Supervised Living, etc.
- Engaging developers/providers as potential partners in housing development and developing a working knowledge of funding sources and how their regulations, income and population targeting, matching requirements, allowable development fees, etc. dictate how they can be combined.
- Providing education to consumers, families and service providers on accessing and maintaining affordable housing: NC Landlord-Tenant and Fair Housing law and negotiating Reasonable Accommodations.

The Division would like to incorporate what has been learned from the experience of the local housing specialists that have been funded through adult mental health. The LME should assure that the spectrum of housing needs is included within the community capacity building functions of the LME. The LME may choose to maintain this function within their administrative structure or contract with an existing or newly developed local community non-profit, including generic affordable housing providers and developers that serve the community at large. The activities of housing resource development will not be disability specific, but for the benefit of the target populations. Housing resource development staff will not be providing direct services to consumers but will work with community partners to develop a range of housing/residential capacity within the LME geographic area.

The Division intends to provide leadership on housing resource development within its new structure. In addition to promoting linkages and the exchange of information between LMEs, the Division will provide technical assistance and training on ways to maximize existing housing resources and best practice in developing residential and supportive housing services. Local LME and Division initiatives will coordinate across agency lines, at the state and local level and support DHHS efforts to speak and act collectively in our approach to the affordable housing system for the benefit of extremely low income persons with disabilities.

Community Hospitals

Local hospitals play a unique role in assisting area programs/LMEs to carry out their mission. To appreciate their importance, one only needs to consider the fact that the local hospital emergency room is, generally, the place where, by design or default, people in psychiatric crisis present. In view of this, it is expected that local community hospitals will be involved in the on-going development and implementation of the strategic local business plans. Since the advancement of

the local business plans could affect the hospitals as health care delivery systems, involvement should include the hospitals' strategic or policy level staff.

There is a great deal of reform-related emphasis in the areas of access and responsiveness, development of a comprehensive provider network and the transition from state operated facility-based services to community-based services. The following three key considerations could or should involve the community hospitals:

- **Access System:** A good number of individuals in crisis present at the community hospitals. Therefore, community hospitals, whether or not they have inpatient behavioral units, should be considered as a viable component of the communities' access system. This could include screening/evaluation, inpatient admission and alternatives to inpatient services for individuals in crisis who meet medical necessity criteria.
- **Provider Network:** Along with the inpatient/crisis services that may be offered, there are other types of community-based services that the community hospitals may have the expertise to develop or provide. Community hospitals may consider developing capacity in other community-based service modalities such as day treatment, in-home care and consultation, etc. This would facilitate the expansion of community capacity starting with the clinical expertise and existing administrative infrastructure in place at the community hospitals. The services would be expected to comport with the fidelity of best practice models in mental health and substance abuse.
- **Community Resource:** Regardless of whether community hospitals desire to be a part of the access system or provider network, they are a valued community resource. There is a need to recognize and develop a system that assures timely, and appropriate response to individuals in psychiatric related crisis who present in local hospital emergency rooms. Support from the area programs will be critical in planning for these services, and on-going local planning should reflect that community hospitals have been invited to actively participate as a stakeholder system and a service provider.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) has formed a task force including representation from the community hospitals in North Carolina. The purpose of this task force is to identify and problem solve policy barriers to the valued and necessary inclusion of the community hospitals as a partner in systems reform. The efforts of the task force will include other stakeholders as relevant issues are identified. Developments by the task force will be shared with the field as they occur.

Physical Health

Many clients with mental health, developmental disability and/or substance abuse problems lack a regular medical provider despite the recognition that many of them have, or are at risk for, serious physical health problems. Many of these have poor and risky health practices include poor diet, lack of physical exercise, smoking, illegal drug use and unprotected sex. Clients are at risk for a number of poor health outcomes including HIV, STDs, hepatitis, breathing problems, etc., that predictably result in excess mortality and morbidity. Providers should actively link clients to medical providers, regularly counsel clients about behaviorally related health risks and work with medical providers to coordinate medical care with mental health, developmental disabilities and substance abuse services. Network service providers are encouraged whenever possible to

provide on-site medical services to reduce barriers to medical care. Physical health services should be coordinated across systems.

Chapter 5: State System Supporting and Serving Our Citizens and Communities

North Carolina's Department of Health and Human Services (DHHS) is ultimately responsible for the provision of services to the citizens of North Carolina who experience the most severe forms of mental illness, developmental disabilities and/or substance abuse. The DHHS Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) is designated as the organization to oversee those services and to implement mental health reform as required by Session Law 2001-437 under the direction of the Secretary of DHHS. The Division is collaborating with other DHHS divisions as well as other departments of state government as part of the reform effort. The Legislative Oversight Committee and the Commission for Mental Health, Developmental Disabilities and Substance Abuse Services are essential in providing leadership and direction for reform.

One key to reform is the active participation of members of the community – the individuals and family members affected by mental illness, developmental disabilities and/or substance abuse who can best represent the perspective and needs of those we serve. The law calls for the DHHS secretary to appoint a state consumer and family advisory committee (S-CFAC) to work directly with the Division leadership to implement reform. The S-CFAC will be developed during state fiscal year 03/04. Further, to accomplish requirements of reorganizing the DMH/DD/SAS, the secretary of DHHS and the Division's Executive Leadership Team (ELT) reorganized the responsibilities and functions of the Division.

This chapter provides a brief overview of the S-CFAC and of the reorganized DMH/DD/SAS.

State-Consumer and Family Advisory Committee (S-CFAC)

Consistent with the intent of reform efforts, the DHHS secretary will convene a State Consumer Family Advisory Committee (S-CFAC). The S-CFAC, in conjunction with the Division's Executive Leadership Team (ELT), will provide input and conduct oversight of the Division's operations and efforts to accomplish the strategic outcomes of the State Plan. Participation at the state level ensures direct access to the ELT to bring forward the concerns and input of the local CFAC groups in their communities.

The S-CFAC ultimately reports to the DHHS Secretary. Therefore, although the S-CFAC works with the ELT, they may, at any time, report concerns to the Secretary. The S-CFAC will also meet with the Secretary at least annually to provide a summary of the S-CFAC's perspective regarding Division efforts.

During 2002, a workgroup composed entirely of consumers and family members were charged with reviewing the State Plan and making recommendations to the Division regarding involvement of

consumers and families in the new system.⁶ Given the breadth of this subject area, two sub-workgroups were formed: one on human rights and one on recommendations regarding the consumer/family advisory committees (CFACs). As a result, the workgroup formulated the following final recommendations or advice to the Division regarding the implementation of the S-CFAC.

S-CFAC Purpose and Work Plan

The workgroup endorsed the purpose, roles and responsibilities of the S-CFAC as expressed in the State Plan and the Division's Re-organization Plan. As stated in the State Plan, the roles and responsibilities of the S-CFAC will be established according to specifications in the state's strategic plan. They must be consistent with the principles of the State Plan and address the following:

- Advise and comment on all state and local plans.
- Recommendations on areas of service eligibility and service array, including identifying gaps in services.
- Assist in the identification of under-served populations.
- Provide advice and consultation regarding development of additional services and new models of service.
- Participate in monitoring service development and delivery.
- Review and comment on the state and local service budgets.
- Observe and report on the implementation of state and local business plans.
- Participate in all quality improvement activities, including tracking and reporting on outcome measures and performance indicators.
- Ensuring consumer and family participation at all quality improvement projects at both the provider and LME levels.
- S-CFAC develops an interaction and operationalization protocol with local C-FACS.

The S-CFAC work plan should be developed by the S-CFAC membership with direction from the DHHS Secretary and the Division Director. However, the workgroup noted the following material as being pertinent to the S-CFAC's work plan development.

- "Report of the assessment provided by the State–Consumer Advisory Committee and added to the annual revision of the State Plan," (*State Strategic Business Plan*, 2002, Item I.A-1).
- "State–Consumer Advisory Committee assesses the Division's progress in obtaining meaningful involvement of consumers and families in planning activities and presents report to the LOC annually" (*State Strategic Business Plan*, 2002, Item I.A-3).

⁶ During 2002, the Division established three State Plan committees charged with planning and making recommendations regarding implementation of the State Plan. These committees were divided into various workgroups. Implementation Committee 2, on Quality Care, included a Consumer/Families and Human Rights Workgroup composed entirely of consumers and family members. The membership of the State Plan implementation committees and their workgroups can be found in *State Plan 2002: Blueprint for Change*, Appendix A. These committees and workgroups completed their tasks during 2002.

- “Quarterly reports by S-CFAC provided to the Secretary and added to Division reports,” (*State Strategic Business Plan*, 2002, Item II.B-1).
- “[S-CFAC] Members assigned to various workgroups and implementation teams and supported in their participation,” (*State Strategic Business Plan*, 2002, Item II.B-1).

S-CFAC Membership

- The S-CFAC should consist of not more than twenty (20) members.
- There should be equal representation of individual consumers and family members of consumers (parent, spouse, sibling or guardian).
- There should be equal representation of each of the following four (4) disability groups: mental health, developmental disabilities, substance abuse and co-occurring disabilities (persons with more than one disability, e.g., MH/DD, MH/SA, DD/SA).
- The representation for each of the above four (4) disability groups should be as follows:
 - Up to two adult consumers.
 - One youth consumer (minor).
 - One family member of an adult consumer.
 - One family member of a youth Consumer (minor).
- Membership on the S-CFAC should not be limited to individuals who are members of local CFACs. At least 16 S-CFAC members should be local (LME) CFAC members. Not more than one member from the same local CFAC should serve on the S-CFAC at the same time.
- The S-CFAC membership should reflect the population of the State in terms of race, gender, ethnicity, culture, age and geography. Geographical considerations should include proportional representation from both rural and urban areas and from each of the three regions established by *State Plan 2002: Re-Organization Plan*. The S-CFAC will reflect an equal representation of all disability groups as well as race and ethnicity of the community, and include a man, a woman, and a youth member. (Family members may represent children. While a parent may represent the needs of adult consumers, they may not replace having adult consumers on the committee.)

The recommended size of the S-CFAC is sufficiently large to allow for effective and appropriate representation in acknowledgement of:

- The primacy of the S-CFAC as a vehicle for advancing State Plan principles and vision regarding consumer and family involvement and continuous quality improvement.
- The distinctive and often evolving needs of individual consumers of varying age with separate and/or co-occurring disabilities.
- The needs of children and of those adults who are unable to advocate for themselves.
- The different and unique needs of families of consumers as distinct from those of the consumers.
- The geographical, racial, gender, ethnic and cultural diversity of the State.

Term of Office

1. The term of service should be three (3) years, with the following exceptions for the initial membership:
 - (a) Six members would be appointed for an initial one-year term,
 - (b) Six members would be appointed for an initial two-year term, and
 - (c) Eight members would be appointed for an initial full three-year term.
2. All subsequent appointments would be for a three-year term.
3. Members appointed for an initial one or two-year term could be re-appointed for a subsequent full three-year term.
4. Individuals should not be appointed for more than two consecutive terms.

Member Selection

Nominations

1. Nominations for appointment by the DHHS Secretary to the S-CFAC should be invited from local CFACs, consumer and family advocacy organizations and other groups to produce a maximally diverse pool of nominees consistent with the compositional criteria.
2. Special attention should be paid to the recruitment of potential nominees from under-represented groups, particularly Hispanics.
3. Self-nominations from individual consumers and family members should be encouraged.
4. Nominations should be promoted through the placement of notices in local newspapers, on the web and by circulating a form that could be used by consumers and family members to express interest in serving.
5. The nomination form should allow an interested person to list pertinent experience, skills and interests. The form should invite:
 - Evidence of pertinent advocacy and other related experience.
 - Knowledge of the service and support needs of persons in one or more of the four disability groups (see Composition above).
 - A statement as to why the person wants to be considered for appointment.
6. Nominations/nomination forms should go directly to the DHHS Secretary or his/her designee.

Selection Process

The workgroup supported the DHHS Secretary, as the appointing authority, to develop and carry out an open and inclusive S-CFAC selection process consistent with mental health reform legislation, DHHS policy and goals, and the guiding principles and vision expressed in the State Plan. Political affiliation should not be a factor in selecting S-CFAC members.

Times, Dates and Places of Meetings

The work group stated that the S-CFAC membership should determine operational matters with guidance from the DHHS Secretary and the Division Director and with reference to pertinent requirements in the State Plan, the state's strategic plan and the Division's re-organization plan. It was noted that the Division's reorganization plan implies that the S-CFAC will meet at least monthly with the ELT or other staff as needed. In addition to meeting annually with the DHHS Secretary, the S-CFAC may contact the DHHS Secretary at any time regarding concerns about the Division.

Support to Consumer/Family Members to Ensure Meaningful Participation

The workgroup recommended that action on this matter be assigned to the appropriate Division staff and/or teams as soon as possible. The workgroup offered to assist with these tasks, including the identification of prime and time sensitive support components necessary to ensure the successful recruitment, selection and participation of CFAC members.

The following are identified as important support elements requiring immediate attention:

- The establishment of realistic and appropriate supports, per diems, transportation/travel and subsistence allowances or stipends, including transportation and subsistence advances, necessary to encourage and permit the participation of low income consumers and family members on the S-CFAC.
- The establishment of realistic and appropriate childcare, eldercare and respite care allowances as needed to encourage and permit consumer and family participation on the S-CFAC.

Support for consumer and family participation is addressed directly or obliquely at several places in the 2002 State Strategic Business Plan, including:

- Item I.A-3 (d) includes a task/strategy "Develop mechanisms that support meaningful and ongoing involvement of consumers/families in all sub-plans required by this strategic plan.
- Item II.B-4 (a) includes a task/strategy "Disseminate guidelines for consumer involvement and/or participation to prospective LMEs." The associated outcome/product is "Consumer/family guidelines disseminated and added to LOC quarterly report."
- Item II.B-5 (a) includes a task/strategy "Establish a process for recruiting and supporting consumers/family members as participants on boards & commissions." It assigns the associated outcome/product to the Office of Advocacy and Customer Services.
- Item II.B-5 (b) includes a task/strategy "Assign responsibility for implementation and oversight of necessary and effective supports for consumers/family members to ensure ongoing participation and meaningful involvement." It assigns the associated outcome/product to the Office of Advocacy and Customer Services.

- Item IV.E-3 (d) includes a task/strategy “Create training and information opportunities, including material development and financial and other supports, to support the education and leadership development of consumers and families.”

The workgroup stated that the combination of the above will provide ongoing support for meaningful participation by S-CFAC members. However, they expressed concern that the various timetables for task completion must generate the essential early support necessary for a vibrant and effective S-CFAC.

S-CFAC Reporting Process

Finally, the workgroup stated that the S-CFAC’s reporting process should be developed by the S-CFAC membership with appropriate direction from the DHHS Secretary and the Division Director and in concert with applicable elements of the State Plan, the reorganization plan, the state’s strategic plan and local business plan requirements.

Division of Mental Health, Developmental Disabilities and Substance Abuse Services Organization

The leadership of the Division has implemented a new organizational structure that is established for the pursuit and advancement of the State Plan and reform efforts. The new structure is composed of the Director’s Office and five sections – Administrative Support, Advocacy and Customer Services, Community Policy Management, State-Operated Services and Resource/Regulatory Management. The Division is further organized into teams, each of which is responsible for a particular substantive and technical area of expertise. Teams work with and across sections and teams, recognizing that in order to accomplish anything we rely on each other. The following is a summary of the function of the sections and teams in the new organizational structure. A more complete description of the organizational structure is available on the Division’s web site at <http://www.dhhs.state.nc.us/mhddsas/stateplanimplementation/index.html>.

Advocacy and Customer Services

This section is responsible for leading the Division’s efforts to create a community where people with disabilities are valued and treated with dignity, and where stigma, accompanying attitudes, discrimination and other barriers to recovery are eliminated. It is composed of the following three teams:

Consumer Empowerment: This team ensures consumer and advocacy voice and disability representation in Division planning implementation, management and improvement efforts and is responsible for:

- Assisting in the development of local grass roots consumer controlled advocacy groups and organizations.
- Providing technical assistance and consultation to local consumer and family advisory committees (CFACs).

- Monitoring the efforts and achievements of the local CFACs to ensure their empowerment to perform their role/responsibilities.
- Providing support and technical assistance to self-advocacy initiatives.

Customer Services and Community Rights: This team has three key responsibilities:

- Ensuring the rights protection of consumers being served in the community.
- Providing a response system for customer complaints and appeals.
- Monitoring the community customer services systems.

State Facility Advocates: This team is responsible for ensuring that the rights of consumers are protected. Advocates manage case investigations and system improvement efforts for client advocacy services provided for residents of state-operated services.

Community Policy Management

This section is primarily responsible for leadership, guidance and management of relationships with local management entities (LMEs). This section is recognized as the responsible public policy and oversight agent. This section will collaborate with a wide variety of public and private partners and customers to promote recovery through the reduction of stigma and barriers to services. Special emphasis is placed on relationships with federal departments and agencies. This section performs the functions of the single state agency (SSA) for substance abuse and of the state methadone authority. It also performs the functions of the single state agency (SSA) for mental health and developmental disabilities as required by federal law. This section is composed of the following five teams:

Best Practice and Community Innovations: The primary purposes of this team are improving and strengthening the system through development of best practice platforms and models and establishing a system that more effectively connects services and research, with the goal of providing treatment, services and supports based on the best scientific evidence.

Justice System: Relative to justice systems, this team will continuously research, disseminate and advance relevant best practice and innovations in the areas of mental health, developmental disabilities, substance abuse and specialty supports and services. Further, it will implement and manage unique programs and special projects.

Local Management Entity Systems Performance: The responsibilities of this team include:

- Leading and coordinating the Division's efforts to develop, negotiate, monitor and manage contracts with the local management entities (LMEs).
- Coordinating across Division teams to conduct scoped site reviews of LMEs when there is evidence of problems with specific areas of best practice or emerging best practice or compliance, performance and/or outcomes.

Prevention and Early Intervention: Designated as the Office of Substance Abuse Prevention, this team will also develop an appropriate evidence based prevention framework for mental health and developmental disabilities. Responsibilities include early intervention services for children and coordination of many of the Division's financially related agreements, grants and contracts.

Quality Management: The primary purpose is to establish for Division, state-operated facilities, LMEs, providers and contracts the standards of quality and required performance measures specifying how quality is defined, monitored and managed.

Resource and Regulatory Management

This section is responsible for supporting the efforts and ensuring accountability of all operations of the Division. This section is composed of the following five teams.

Accountability: This team is responsible for ensuring overall fiscal integrity within the Division including state-operated services and the community system, including:

- Ensuring compliance with federal and state regulations, standards and policies and assuring fiscal oversight.
- Monitoring fiscal audit standards and financial regulatory standards in the field as well as the Division's efforts of fiscal oversight.

Budget and Finance: This team is responsible for comprehensively planning, developing, implementing and managing budget (expenditures) and finance (revenue) strategies for the Division's total budget. During State Plan implementation, emphasis focuses on changes in the service financing structure to maximize resources and support additional community capacity building.

Contract Management: This team will support the implementation of the State Plan in three primary areas:

- Ensuring contracts are performance based, monitored and developed in accordance with all state and federal requirements.
- Ensuring compliance with all federal requirements related to block grants, cooperative agreements, contracts and other grants.
- Managing property, maintenance, surplus disposal, purchasing and employee parking.

Information Systems: This team is responsible for comprehensive planning, developing, implementing, managing and improving the Division's computer network, warehouse, hardware, software and technical support functions, including: systems such as the state Health Enterprise and Accounts Receivable Tracking System (HEARTS) and the Integrated Payment and Reporting System (IPRS) and all data sources; and coordination with DHHS information technologies and systems efforts.

Regulatory: This team is responsible for ensuring regulatory compliance, including:

- Coordination of Medicaid waiver and State Plan developments with DHHS.
- Management of Division responsibilities regarding DWI and drug enforcement.
- Completion of pre-admission screening and annual resident reviews (PASARR).
- Completion of Intermediate Care Facility-Mental Retardation (ICF-MR) level of care determinations.
- Completion of provider enrollments.
- Provision of interpretations of federal and state regulations.

State-Operated Services

This section ensures exemplary practice related to the operations of state facilities and the transition from state-operated services to community capacity developments. The Division holds a dual role as manager and provider of state-operated services and facilities and is held to the same quality and best practice standards as are local management entities (LMEs) in overseeing local service delivery. State-operated services and facilities will be organized into three teams corresponding to three regions of the state – west, central and east – to allow for a more effective and efficient system.

Administrative Support

This section is responsible for providing administrative support and ensuring coordination with DHHS for all operations components of the Division. It is composed of the three following teams.

Communication and Training: This team is responsible for:

- Increasing public awareness regarding the efforts of the Division, particularly as related to reform.
- Coordinating media relations for the Division with DHHS.
- Developing and disseminating information and communications regarding Division activities.
- Developing a comprehensive training plan for advancing Division members' competencies in coordination with Human Resources.
- Developing training opportunities necessary for carrying out reform efforts.
- Serving as the liaison to universities, community colleges and AHECs to facilitate training for the State Plan.
- Development strategies to address workforce issues.

Division Affairs: This team is responsible for:

- Advancing collaborative efforts among divisions of DHHS.
- Participating in and creating new partnerships to foster reform.
- Coordinating the development of rules, policy and legislation with DHHS and serving as legislative liaison for the Division.
- Managing and monitoring Division programmatic due process appeals functions.
- Staffing and supporting the Commission for Mental Health, Developmental Disabilities and Substance Abuse Services.

Planning: This team is responsible for:

- Providing technical oversight and coordination in implementing and managing the State Plan and the Strategic Plan and related reports.
- Providing a range of technical planning assistance (from brief consultation to plan management) for all Division planning endeavors.
- Service in the role of project manager for specific initiatives.

The Division's reorganization plan was reviewed and approved by the Division's Reorganization Stakeholder Advisory Committee, the DHHS secretary and the DHHS assistant secretary of health

in November 2002. Implementation of the plan was completed in March 2003. A copy of the organizational structure is offered as appendix C.

Chapter 6: Operationalizing the Plan

In order to understand how to operationalize the plan, it is essential to remember the developmental stages of reform. SFY 01/02 (State Fiscal Year July 1, 2001-June 30, 2002) was a time for establishing an understanding of the foundation of reform. SFY 02/03 was an opportunity for clarifications and adjustments regarding design elements and expectations of reform. SFY03/04 will involve the completion of operational detail with extensive attention to system transition. SFY 04/05 and beyond will involve comprehensive implementation and continued strategic evolution.

Following the developmental process summarized above, this Chapter provides an overview of the efforts to operationalize the state plan. The process of moving the system forward is best described over a three-year period, as follows:

- **SFY 02/03 Outcomes:** (1) Completion of critical reform related organizing principles and corresponding design expectations, and (2) development of the essential structure to support reform.
- **SFY 03/04 Intended Outcome:** (1) Transitioning the design and structure through discrete operational developments.
- **SFY 04/05 Intended Outcome:** (1) Initiating the evolution of the system in order to fulfill the vision and mission of reform.

Clear direction and policy was needed before the concepts and principles of reform could be put into detail for the operations at the state and local level to be supported as well as understood by the various stakeholders such as the area programs, county programs, families/consumers and providers. SFY 02-03 served as the year to clarify those concepts. Some of the major areas included: the development and submission of the local business plan; the development of the cost modeling for a local management entity (LME); the flow of the uniform portal and access system; the release of the revised service definitions, including provider qualifications and utilization management guidelines; identification of target populations and non target populations; implementation of the Integrated Payment and Reporting System (IPRS); expansion of community capacity as associated with the Olmstead decision and state facility downsizing; and providing training and education regarding the intent of reform.

These developments contribute to the next stage of reform. The upcoming year will concentrate on phasing in the implementation of those decisions. As we move forward with the operations of reform, the major areas of focus for SFY 03/04 include target and non-target populations, assessing community and state systems serving target and non-target populations, and overall financing strategies for the system including local management entities and services to consumers and their families. Attention will also be given to assisting LMEs in the development of provider networks. Within each area, there are many details that must be established and communicated,

business or clinical practices changed and rules amended, all while assuring that the actions taken by the stakeholders are within the parameters of system reform and their local approved business plan. Although not included in this document, the Division of MH/DD/SAS will maintain and publish an operations plan regarding the steps being taken to implement the details of reform. This list will be posted on the DMH/DD/SA web page and periodically updated regarding the status of the plan and will include revisions and products completed.

On September 27, 2002, a Director's Communication Bulletin series was established to provide a single point for distributing key developments regarding reform. Communications were distributed addressing the issues of target populations, housing, local business plans, key questions and answers, community hospitals and adult mental health best practices. They were distributed to a wide audience of consumer and family organizations, area/county programs, county commissioners and managers, various stakeholders, and the provider community. The communications are posted on the Division's web page as well. This process will continue to be used to update any developments of reform after the publication of this plan (State Plan 2003). As the decisions are reached, products produced and implementation steps are prepared as outlined in the subsequent section of this chapter, this communication series along with the Medicaid Bulletin and the Division of MH/DD/SAS web page will be used to distribute and communicate the information.

It is noted that there are considerations of greater flexibility included in this chapter. This flexibility is intended to support community transitional needs. These flexibilities are not intended to negate or stand in the way of community systems that have been pursuing reform in an appropriate and aggressive manner. These flexibilities are intended to address the needs of communities who have been making great efforts to earnestly support and appropriately pursue reform efforts and have encountered legitimate barriers or circumstances that have contributed to a slower pace of development. However, these flexibilities are not intended to create opportunities for stalling or stopping reform efforts within systems that have not earnestly embraced the difficult challenges of change that will result in a better system for North Carolina.

The major areas of operationalization that will be addressed in this chapter include the following:

Citizens We Support and Serve

- *Target and Non-Target Populations*

Supporting and Serving our Citizens

- *Clinical Supports and Services*
- *Administrative Supports and Services*

State and Community Systems Working Together

- *Partnering with Consumers and Families*
- *State - Local Public Partnership*
- *Public - Private Partnership*

In this chapter, there are several major products that will be delivered during SFY 03/04. The development, implementation and management of these products are included in the discrete and detailed operations plan, which is available on the Division web site at:
<http://www.dhhs.state.nc.us/mhddsas/stateplanimplementation/index.html>.

A summary of the major products to be delivered, by SFY 03/04 quarters, are as follows:

SFY 03/04 1st Quarter (July 1, 2003 through September 30, 2003)

- LME Cost Model Implementation Plan.
- County Maintenance of Effort (MOE) Guidelines.
- Rollout of New Supports and Services Plan. (Note: This plan will include proposed supports and services, provider qualifications and rates pending federal and state related approvals.)
- Children's Services Plan.
- Comprehensive Training and Education Plan (new supports and services related).
- Comprehensive Provider Network Guidelines.
- Updated overview of area/county program fiscal settlement for SFY 04 based on changes included in the updated State Plan.

SFY 03/04 3rd Quarter (January 1, 2004 through March 31, 2004)

- Completion of negotiated Division/LME performance-based contracts for SFY 04/05.
- Plan to address inequities in community funding.
- Long-term finance strategy.

Each of the products identified above in SFY03-04 will include comprehensive and discrete detail, supporting products and conditions necessary to operationalize the plan, clear action steps, timelines and a process for product management. In reviewing the summary list above and reading through this chapter, the reader should consider the following:

- The products to be delivered are ordered by quarter. This reflects the necessary sequence. The order within each quarter is not sequenced.
- A great deal of work has been completed for all of the products identified for the first quarter of SFY 03/04. These work efforts include consideration of work products provided by the SFY 01/02 State plan work groups. Most of SFY 02/03 has involved coordinating all product development efforts into appropriately integrated comprehensive and complete products.

Managing the Challenges of Change: The Citizens We Support and Serve

- **SFY 02/03 Outcomes:** (1) Established target populations, (2) Initiated community transition to support and serve the target population, (3) Evaluated non-target populations to determine if any adjustments were needed, and (4) Continued state facility downsizing activities with a concurrent development of additional community capacity through the transfer of resources from state facilities to community programs and the utilization of the MH/DD/SA Trust Fund.
- **SFY 03/04 Intended Outcomes:** (1) Complete any adjustments to the target populations based on Area Program learning during the transition to the target populations, (2) Continue transition to target populations, and (3) Provide technical assistance around natural and community supports for non-target individuals.
- **SFY 04/05 Intended Outcomes:** (1) Support and serve the target populations, and (2) Continue evaluation of the target populations to determine necessary adjustments.

Target and Non-Target Populations

In SFY 02-03, the following communications were distributed regarding target populations and non-target populations.

- Memorandum to Area Directors, Area Board Chairs and County Managers dated September 13, 2002, regarding “Service Transition for Individuals Not Included in MH State Plan Target Populations.” This memorandum outlined the process for area programs to evaluate their current caseloads to determine who met or did not meet the target population criteria and the process by which the area programs would continue to get paid for serving the non-target population during the fiscal year. This process included the clarification of cash flow while implementing the Integrated Payment and Reporting System (IPRS) and financial year-end settlement procedures.
- State Plan Communication Bulletin #003, dated October 28, 2002, regarding “Management of State Plan Target and Non-Target Populations.” This document provided more direction regarding the establishment of resources to serve non-target populations while re-emphasizing the role of transition and area programs’ ongoing responsibility to continue to serve consumers as they began to build alternative resources.

A key element in system reform is to ensure that individuals that fall outside of the target populations are appropriately assessed and effectively linked with alternate community resources to meet their needs. Reform efforts which seek to focus finite resources on individuals with the greatest need must not, and cannot, lose sight of the need to address transition and long term needs of individuals who will no longer be within the identified target populations. As described in Chapter 4, system reform provides the framework for the local system organization, including networks and services for target and non-target populations.

The period of July 1, 2002 through June 30, 2003 was initially designated as the period during which area/county programs identified individuals who would not fall within the target population groups as defined in the State Plan 2002 Chapter 3, Section – Target Populations. Transition planning began for all persons served in area/county programs and contract agencies, as well as beginning to identify strategies for engaging or identifying those people who should be in the system or meet target population. As stated in communications, it was critical that “individuals not be discharged or transitioned to other services and supports without careful planning, therefore, individuals within the non-target populations will be assisted in moving to other alternatives within the community over a reasonable period of time.” During last year, the Division, in conjunction with area/county programs, collected data from area/county programs related to individuals falling outside of the target populations. During April and May 2003, the Division assessed the information collected in SFY 02-03 to determine if changes were needed in the target populations. Chapter 2 includes modifications to last year’s published target population criteria based upon review of the data collected from the area programs for SFY 02-03.

In order to address the specific issues related to individual community network and resource capacity and the scope of those individuals who have been identified as non-target population, the Division will work with each LME regarding the transition. This process will include an extension of authorization to expend Division funds to serve non-target populations to June 30, 2004, while the Division works with LMEs to ensure full transition of non-target populations by no later than June 30, 2004. It is not the intent of the transition for LMEs or providers to continue to provide services to consumers and families as a means to avoid the transition to target population or to avoid the development of alternative network sources and resources. Rather, it is recognition of the diversity of the communities in terms of available community resources and the need to ensure that individuals not included in target populations transition to alternate community services and supports in a safe and planned manner.

The transition process for serving target and non-target populations has included completing consumer assessments to determine whether individuals qualified for target or non-target populations. Through this process, the type of care and level of care needed by individuals was identified. In this process, and in the future assessments, it will be essential to determine if individuals are being served with best practices and at the appropriate levels and to ensure that person-centered planning will continue to shape service delivery. If the current type of service is not best practice, or if the service level either exceeds or falls short of that indicated for the individuals, then the need for the type of service and/or the level of care must be realigned. This process will help assure the optimal use of resources for individuals who are most in need of services, while addressing the needs of individuals in the non-target populations. As a function of the LME, service coordination should not only address individual consumers but also should assist with the development of service and support capacity for non-target population. This includes demonstrating a system that is responsive to those individuals who show signs of deterioration or who need an elevated level of care.

In future years continued community management by the LMEs as well as the Division will allow adjustments to the target populations based on sound empirical evidence of need and public policy expectations.

Managing the Challenges of Change: Supporting and Serving our Citizens

Clinical Supports and Services

- **SFY 02/03 Outcomes:** (1) Developed fundamental expectations of support and service best practice, (2) Developed state guidance regarding hospital downsizing and concomitant flow of funds to support community capacity, and (3) Developed a plan for technical support for communities in transitioning DD Olmstead clients.
- **SFY 03/04 Intended Outcomes:** (1) Distribute approved service definitions with accompanying provider qualifications and utilization management guidelines, (2) Submit a newly revised Medicaid State Plan in keeping with best practice, (3) Set a timeline and provide training and information for systems to transition to new support and service expectations, (4) Initiate transition to new service expectations, (5) Develop outcome and performance based contracts for LMEs for SFY 04/05, (6) Track Olmstead efforts and continue to offer technical assistance for these high priority populations, (7) Update changes in target populations as appropriate, and (8) Prepare an outline for a plan that will expand the evidence-based substance abuse prevention initiative to include mental health and developmental disabilities.
- **SFY 04/05 Intended Outcomes:** (1) Continue quality improvement efforts to assure model fidelity of the supports and services, (2) Continue research, dissemination and implementation of new best practices, and (3) Develop incentive based contracting for LMEs in meeting goals related to best practice.

Changes in the service definitions reflect models of practice that are going to be purchased, as well as the manner by which providers must be qualified and organized in order to participate within the public system. This includes expectations that providers will not "pick and choose" whom they support and serve in order to maximize profits or margins, as well as expectations that they are part of a larger community system and part of the LME provider network.

The best practice guidelines presented in Chapter 3 were developed in collaboration with selected expert stakeholders and consultants. In order to implement best practices, the goal is to develop a best practice based service taxonomy and to remove nonessential differences between Medicaid, Health Choice and Division funded services. To accomplish the goal, service definitions and the revised CAP-MR/DD Waiver will be completed in the first quarter of SFY 03/04. This rewrite of the definitions utilizes in a more comprehensive manner, the rehabilitation option under Medicaid, self-determination principles, Home and Community Based waivers (HCBW: CAP-MR/DD) that emphasize a person's integration into their community and in the settings that routine activities of life occur. This includes less focus on traditional office based interventions, more options besides out of home placements and the framework of person centeredness and family focus. As part of the definitions, preliminary utilization criteria and initial provider qualifications are identified and included. This includes the identification of the required standards for licensure for new services and modification of standards for existing services in order to be aligned with best practice

expectations. Upon completion of the review for service definitions, the State Medicaid Plan, the CAP-MR/DD Waiver and state funding definitions will be revised for implementation July 1, 2004. As part of the process, the Division, in conjunction with the Division of Medical Assistance, will publish in the first quarter of FY 03-04 an implementation plan that outlines timelines for actions required for successful implementation, including but not limited to federal approvals, rule revisions and transition planning for systems managers, providers and consumers.

Although the guidelines referenced above and in Chapter 3 include child mental health services, additional work is required to ensure that child mental health services are consistent with North Carolina's mental health reform effort. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services has engaged in developing a comprehensive child mental health plan. The purpose of this plan is to develop a framework in order to improve structural, financing, and organizational issues encountered in serving children with mental health disorders and their families. The plan will address services for all children who receive publicly funded mental health services, including those who are in residence at state facilities and those who are served in the community. It is anticipated that the comprehensive child mental health plan will foster an increase in the utilization of community-based services, informal services and supports. Consequently, it is anticipated that the plan will permit a decrease in unnecessary placement in residential facilities and state psychiatric hospitals.

To assist in this planning process, the Division is working closely with community stakeholders through the State Collaborative for Children's Services. Many members of the State Collaborative are serving on the 35 member advisory group for the plan which includes representatives from juvenile justice, social services, public health, public instruction, area mental health programs, child residential facilities, state psychiatric hospitals, universities, advocacy groups and parents of children with serious emotional disturbance.

Future planning efforts will focus on the development of specific action steps, outcome measures, accountability and public feedback mechanisms. The target date for completion of this plan is the first quarter of SFY 03/04.

With the publication of the best practice guides and the modifications of the service definitions, one of the first focuses of change is the recognition of the training and education needed at every level in order to prepare providers and their staff, families and consumers and other stakeholders. This includes not only formal educational opportunities but also an ownership of on-going relationships and processes that reduce stigma, promote cultural proficiency and develop a competent workforce. In order to facilitate this change, a comprehensive training and education plan will be developed by the first quarter of SFY 03/04. This plan will build upon the competencies established during the last year and expand to the newly identified services including case management. In addition, the plan will include the identification and development of resources at the pre-service, in-service and formal professional training at all levels of the state's educational system. Universities, community colleges and area health education centers (AHECs) are valuable partners in the retraining and future training of the professional and paraprofessional staff in the system.

As part of the local business plan development, area/county programs have assessed the availability of providers. As expected, availability of providers varies within the catchment areas as well as in the scope and diversity of providers. Each local business plan identified strategies or goals for building a qualified provider network and ancillary efforts necessary to support the gaps identified. The development of a qualified provider network is critical for successful implementation of reform and to honor the foundations of consumer choice. In order to promote such development providers must have clear expectation regarding the practices expected and standards required. These standards will be outlined in the service definitions and the rules.

The Division of MH/DD/SAS, in conjunction with the Division of Medical Assistance and the Controller's Office will establish the parameters for the provider network including network composition, rate setting requirements, enrollment procedures and procurement procedures. This includes the process for rule making by both the Commission of MH/DD/SAS, the Division of Medical Assistance and by the Secretary. This information will be distributed within the first quarter of SFY 03-04.

The Division is responsible for management of state-operated services and facilities and is held to the same quality and best practice standards, as are local management entities in overseeing service delivery. This is a very unique aspect of the Division in that it holds a dual manager/provider role and responsibility. The State Operated Services section of the Division as a provider of services, is part of the community as a resource to the LMEs and the constituents they serve. The state-operated services are actually part of the LMEs provider network. The state local relationship is particularly important with regard to clients' transitioning from state-operated facilities into a community-based system of supports and services. Clients will have in place, prior to transition, person-centered plans that adequately address their array of needs and that are approved by the state and local systems.

The state's facilities of DMH/DD/SAS must be committed to best practices and must ensure exemplary management in the operation of the facilities. They must also be partners, leaders and trainers in the transition of state operations to community capacity developments. In order to achieve the expansion of services in the community, the state facilities' expertise will be made available to the LMEs, especially for persons in the community who are in need of specialized services. The state-operated facilities will respond appropriately to the transition of residents from the institution to other supports and services in the community. Necessary appropriate technical assistance will be provided to the community service providers and families of these transitioned residents so those individuals may successfully acclimate to their new services and surroundings.

Concurrent with finance changes at the community level, the Division is continuing with state facility downsizing efforts and the transfer of institution-based resources to the community. As planned downsizing activities are initiated, Mental Health Trust Fund resources are utilized to provide bridge or transition funding for community capacity development, with ongoing operational resources transferred from institutions to the community as downsizing actually occurs.

In order to implement the above, beginning July 1, 2003 utilization of the four state psychiatric hospitals will be determined based upon a Division approved bed day allocation plan. Through this plan, bed days will be allocated to each LME in the following categories: Adult Admissions, Adult

Long-term, Geriatric Admissions, and Adolescent Admissions. Each LMEs initial bed day allocation will be based on its historical utilization, i.e. state fiscal years 00/02, of the subject beds.

During the five-year period of SFY 03/04 through 07/08, the number of bed days available for allocation will be reduced as the number of beds in the hospitals are reduced. The reduction in the number of hospital beds will be facilitated by the transfer of funds from the hospitals to the LMEs. As the funds are transferred to the LMEs and hospitals are downsized, the bed day allocation will move from one based on historical utilization to one based on the per capita population of the LME.

While access to the hospitals will continue to be governed by the current rules outlined in Admission and Discharge of Patients to State Psychiatric Hospitals, the Division will develop the necessary processes to implement the bed day allocation plan and modify the rules accordingly. Other rule modifications may include those necessary to enhance the relationship between the state facilities and the LME, in such areas of uniform portal and best practices.

As part of the unbroken chain of accountability, decisions regarding certification and accreditation that affect LMEs and providers (both agency based as well as independent practitioners) will be communicated within the first quarter of SFY 03-04. In addition, the LME will be responsible for implementing the monitoring required under SB 163, effective July 1, 2003. In a phase-in process of implementation, monitoring protocols will be developed with accompanying training and monitoring plans will be developed at the local levels between the providers and the LME.

Administrative Services and Support

- **SFY 02/03 Outcomes:** (1) Reviewed and provided guidance on the local business plan submissions, (2) Continued development of the funding formula and plan for the administrative functions of the service delivery system, (3) Determined LME administrative functions, and (4) Provided public policy guidance on the roles and functions of the LME—specifically related to divestiture of services and developing community capacity.
- **SFY 03-04 Intended Outcomes:** (1) Develop funding formula and plan for the service system, (2) Develop rates for services, (3) Develop plan for cost settlement for SFY 03/04, (4) Determine and provide training for the LME in how the funding plan will be implemented. (5) Continue to provide technical assistance in building community capacity for service and service divestiture, (6) Move to aggregate funding for CAP MR/DD services, (7) Finalize development of a long-term finance strategy, (8) Complete the LBP certification process for all systems approved as LMEs—including the approval of continued service provision per the state guidelines, (9) Develop the performance contract for SFY 04-05 —including incentives for exemplary service networks and service providers, and (10) LME cost model implementation plan.

- **SFY 04-05 Intended Outcomes:** (1) Fund the LME for administrative functions using new formula and plan, (2) Continue technical assistance and consultation regarding the functions of the LMEs, and (3) Implement relevant components of the long-term finance strategy.

Using the *State Plan 2002, Local Business Plan*, Section 5, area programs submitted local business plans to the Division by April 1, 2003. As outlined in the Director's Communication Bulleting #002, October 2, 2003, "Local Business Plan Submission and LME Certification", protocol for area program quarterly reporting and for on site visits were established. All Phase I local business plans were reviewed and site visits occurred in May 2003. The review of Phase II local business plans began in June with site visits to be scheduled prior to November 2003. The review of Phase III local business plans will begin in July 2003 with site visits to be completed prior to May 2004.

The performance agreement (required annually for area program funding) was revised to include benchmarks from the local business plan implementation. Benchmarks unique for each approved local business plan were established through a negotiated process and incorporated into the Division/LME annual Performance Agreement. In the future, it is planned that the Division will enter into a Contract Performance Agreement in lieu of the current Memorandum of Agreement to reflect the business relationship with Local Management Entities. Contracts between the LME and the State will be negotiated by the end of the third quarter of SFY 03/04 for implementation July 1, 2004.

During the upcoming fiscal year Phase I and II area programs will begin the process of reconfiguring their systems to align with functions and responsibilities of a local management entity. Area programs have three years to implement the strategic plan. Phase III area programs will begin the process in July 2004.

At both the state and local levels, transition and change must happen in order to implement successfully an organized system to support and serve people with mental illness, developmental disabilities and/or addictive disorders. Organizations must change their identity from being stand alone agencies to integrated systems that must cross boundaries and roles in order to maximize resources – resources that occur in every community for every citizen and those specialty supports and services that meet the unique needs of people with mental illness, developmental disabilities and/or addictive disorders.

As an outgrowth of the financial planning and development efforts in SFY 02/03 undertaken jointly with the DHHS Controller's Office and DMA, the Division is exploring conversion of the financing of services from a cost-based model to one founded on accepted, standardized rates. The proposed process of developing the service rates will be through a cost modeling process. This involves examining rate structures from within our state as well as other states to determine rates that best reflect the public policy expectations of the services and providers. Such an approach must not only promote efficiency and consistency across the system but should also eliminate, or significantly reduce, the need for expensive cost finding and non-Medicaid cost settlement activities.

In conjunction with the service definition development, provider qualifications and network requirements must be in place to support the definitions, outline the scope of providers required by the local system, inform providers of their responsibilities and transition current service practices and billing. As a result of those decisions, licensure, rules and policy administered by the Division of Medical Assistance, Division of MH/DD/SAS, the Division of Facility Services, DHHS Controller's Office and other affected departments and divisions must also be modified to support the actual daily operation. The modifications will be published and a feedback period will be scheduled. Upon completion of that process and depending on the specific action required the rule/policy would be implemented in conjunction with the plan for the rollout of the new supports and services.

The Division has undertaken the task of modifying the financing mechanisms with assistance from consultants and partner agencies in the Department of Health and Human Services. Consultants have included the Technical Assistance Collaborative (TAC), Pareto Solutions, LC, and Heart of the Matter Consulting. A Departmental Financing Workgroup, chaired by the Secretary, with representation from the Division, DHHS, Division of Medical Assistance, and various other stakeholders, has overseen the financing work to date. We have also continued to develop the finance strategy described in State Plan 2002. This long-term finance strategy will be developed by the end of the third quarter of SFY 03/04.

The current community mental health, developmental disabilities and substance abuse system is financed primarily through unit cost rates that combine the cost of services and administration. In the reform environment, these cost elements must be separated. Also, to ensure the optimum use of limited public resources, it is proposed that financing be based upon standardized models rather than on the actual costs incurred by entities that may be performing at varying levels of efficiency.

The first element addressed in the refinancing work has been determining the appropriate level of funding for the activities of LMEs. A cost model was developed that identified the primary functions of a LME as defined in legislative and administrative planning documents. These primary functions are:

- General administration and governance.
- Business management and accounting.
- Information management analysis and reporting.
- Provider relations and support.
- Access line, screening, triage and referral.
- Service management.
- Consumer affairs and customer services.
- Quality improvement and outcomes evaluation.

With the primary functions identified, assumptions were made regarding the demand for services that LMEs would experience from citizens in their geographical area and the "best practices" that would be employed by LMEs to effectively fulfill their responsibilities. Using the experience

elsewhere in the country of similar organizations assigned responsibility for managing behavioral health services, a mathematical model was developed that yields a cost per citizen per month (PCPM) to effectively and efficiently deliver the primary LME functions.

In the spring of 2003 the Report on Modeling Costs for the Local Management Entity was disseminated to area programs. The model was designed to estimate the cost of operating a LME according to guidelines set out by the State. Though there are many different ways an area program may fulfill these functions, the responsibilities are those mandated by the State. The final LME cost model will be released in the first quarter of SFY 03/04. Specifications included in the final model will include the method that will be employed to negotiate the per citizen per month (PCPM) with each LME, the financing of the model and considerations for transitional adjustments of the model to meet the transitional needs of LMEs.

SFY 03/04 will be a time of transition in financing. Area/county programs are in different stages of their conversion to LMEs. Some programs have made significant strides in their efforts to divest of services⁷, others have made substantial progress in accomplishing mergers and consolidations to provide for more efficient LME governance. Some organizations may be in a position to implement one or more LME functions in July and others later in the fiscal year. By July 1, 2004, the Division anticipates that LMEs will be funded based upon the standardized model. During this interim SFY 03/04, funding will be adapted as necessary to meet developmental stages of LMEs.

Modifying the financing of the public mental health, developmental disabilities and substance abuse service system is a critical element in the ultimate success of the system reform effort. Appropriate financial incentives will assist reform to go more smoothly; conversely financial disincentives could inhibit reform efforts. The financing method and rates for the new services are intended to create the incentives to return effective and efficient outcomes for people with disabilities. Draft rates for services will be released with the definitions during the first quarter of SFY 03/04. The process of developing the service rates will be through a cost modeling process. This involves examining rate structures from within our state as well as other states to determine rates that best reflect the public policy expectations of the services and providers.

The use of resources needs to be both flexible while also meeting the intent of reform. This factor requires a comprehensive funding plan, not just service rates or LME rates, that outlines the use of the county MOE and third party benefits. This plan will be released by the end of the first quarter of SFY 03/04.

Another goal of system finance reform is to address current inequities in funding. For a variety of historical reasons, variations exist in the current utilization of State institution resources and in allocations of community funding sources. A goal of the Division, and also required in system reform, is to narrow the gap in funding inequity. Narrowing this gap will initiate in SFY 04/05 and will occur over a period of at least five years. This time frame is intended to allow sufficient

⁷ The LME providing services and divestiture options are taken from State Plan 2002 and offered as appendix E.

transition for moving to a realistic range. The plan to address inequities in funding will be developed by the end of the third quarter of SFY 03/04.

The overall finance strategy is intended to ultimately arrive at a more unified funding strategy. This concept involves the integration of revenue sources into a single community system. Public policy management responsibilities of this community system would be the responsibility of the LME. Private providers who are part of the LME provider network would carry out public policy implementation.

The information contained in State Plan 2003 does reflect a change in an option offered to LMEs in State Plan 2002. State Plan 2002 stated that assessment and case management (and psychiatry) could be retained by the LME if it divested of all other services. The discussion of the design described in this communication has raised a great deal of concern regarding these issues.

At the time the State Plan 2002 was completed, there was a great deal of confusion regarding concepts and practices of case management and service management. This created a blended definition of these two very different practices that required additional time to sort out. As we furthered the discussion regarding these two practices, we clearly realized that the models of case management currently applied did not reflect models that are currently used in this field. Case management in North Carolina seemed to largely reflect an inefficient method of a substitute for a management structure. This included a number of activities that are not relevant to appropriate case management models but are relevant to a number of responsibilities that a systems management entity would assume (e.g. quality assurance and improvement, fiscal accountability, network related monitoring, general service system management). That is not to say that a case manager does not have a role in these areas (monitoring the implementation of a person-centered plan contributes to the overall quality improvement efforts, as an example).

The change described in State Plan 2003 is intended to clean up the boundary between what is the responsibility of a systems manager (LME) and what is related to the delivery of service (case management). The foundation for understanding the overall systems strategic design is evident in the best practice support and services description provided in Chapter 3 and the LME cost model.

The inclusion of assessment in the service side is related to both efficiency and practicality. Accredited provider agencies are required to perform the assessment function. In addition, the LME is interested in systems level management, which includes monitoring the quality of assessments. Concerns regarding providers completing assessments in a manner to promote the services they provide is mitigated by the LME authorization process. The provider qualifications for providers of the assessment and person centered planning services will be developed after the service definitions have been completed. The nature of the organization of the provider systems will be addressed in the best practice communications and reflected in the provider qualifications.

There has been discussion regarding the LMEs ability to retain the assessment and case management responsibilities. This has centered on the concept of building a "fire wall" between the management and provider responsibilities. Such a "fire wall" would include where these responsibilities are delegated within the organization and protocols that describe how these

responsibilities interact and address conflict. However, until these responsibilities are truly separated through two separate entities, the principle-agent ⁸problem exists.

With clear definitions of case management and care management, we will find that conducting both the management function and the service function is fraught with complication and conflict. The goal is to clearly separate the management and service functions and to cease using the service function of case management as a replacement for underdeveloped management functions. By developing clear definitions between these two functions and allowing the local LMEs to evolve their systems locally, this goal can be achieved. During this transition, however, the state will establish clear guidelines and oversight to insure the LMEs are developing provider capacity to provide case management and that the principle agent conflict for case managers is not compromised.

One final concern regarding the case management issue is related to changes in expectations to communities who spent time in developing local business plans (LBPs). The state plan was marketed as a process that provided an opportunity for flexible community planning in the design of their system.

Local flexibility in systems design is critical, however it must relate to the need for fundamental expectations of all citizens of the state to be responded to in a common manner. For example, the state defines expectations for timelines in response to access across the state while the local community determines the best methods for them to achieve this expectation. This is also true for the population to be served and the types of services to be provided. The design of management responsibilities is determined by the state. If there were no consistency in these expectations, there would be no statewide consistent management system. The local system determines how to best meet these expectations. As stated in the preceding paragraphs, local flexibility in achieving these goals is needed and noted.

Managing the Challenges of Change: State and Community Systems Working Together

Partnering with Consumers and Families

- **SFY 02/03 Outcome:** (1) Initiated opportunities for people with disabilities and families to shape the reform developments, (2) Hired the advocacy chief and staffed section with primary and secondary consumers, and (3) Evaluated local business plans for meaningful involvement of consumers and families in local plan development.
- **SFY 03/04 Intended Outcome:** (1) Establish the State CFAC, and (2) Provide technical assistance for local programs to increase consumer and family participation.

⁸ Role and responsibility conflict.

- **SFY 04/05 Intended Outcome:** Advance the opportunities for people with disabilities and their families to influence the full range of the system -- from policy leadership to more discrete operations.

Most important to this entire reform effort are the intended beneficiaries – people with disabilities, their families and communities. We must maintain earnest and heart desired efforts to promote opportunities for people with disabilities and their families to assume increasing command of the system. The partnership with people with disabilities and their families is essential to the many relationships that need to be continuously developed. This includes the policy relationship between the public partners – the state and local systems – as the parties ultimately accountable for the management of public policy. This also includes the public-private relationship necessary for the effective and efficient implementation of public policy. The development of these relationships also begin to more fully reflect the "unbroken chain of accountability" necessary for better appreciating roles and responsibilities.

During SFY 03/04 the Division will be supporting the development of the S-CFAC. The guidelines for the S-CFAC were developed in SFY 02/03 by a workgroup whose composition was primarily consumers. The delay in implementing the S-CFAC was related to the need to first re-organize the Division. The new organization is intended to promote the most conducive environment to advance the concept and practice of consumer command. The S-CFAC will be operational by the second quarter of SFY 03/04.

One of the key components of the Division re-organization is the Advocacy and Customer Services section. Like a number of states, it was originally planned to have a consumer ombudsman. However, given the desire to more comprehensively promote real meaningful consumer systems ownership, it was decided to create an entire section. Several key aspects of this section are as follows:

- **Selection of Chief:** The process of reviewing applications, selecting interviewees, conducting interviews, and making recommendations for candidates to the Secretary and Division Director involved a group of nine people-- six of whom were consumers. In addition, a consumer candidate was required for the position itself.
- **Executive Level Leadership:** The Chief of this section is a full and equal member of the Divisions Executive Leadership Team (ELT).
- **Executive Firewall:** Although the Chief of this section reports to the Division Director, he/she may take any matter at any time directly to the Secretary.
- **Systems Firewall:** The advocates of the state-operated facilities report under this section rather than to the state-operated facility Directors as they have done in the past.
- **Consumer Employees:** In hiring into a number of positions in this section, the Division is making efforts to employ consumers.

The Advocacy and Customer Services section continues its development. This is an exciting venture for the Division with the desire for the efforts of this section to greatly influence the

direction and operations of the Division. This section will also take the lead in pursuing the development of and providing the structural support for the S-CFAC.

The functional responsibilities of the LMEs offer an opportunity for consumers to become directly involved with the operations of the organization. These opportunities could be full or part time paid employment, application of various mechanisms of providing compensation in order to support individuals' participation or a simple voluntary arrangement. The following three functional responsibilities of the LME are intended to provide a brief presentation of examples of opportunities for more full consumer participation:

- **Provider Relations and Support:** Network development, orientation and training, monitoring.
- **Consumer Affairs and Customer Services:** Systems navigation, responding to customer inquiries and conducting consumer satisfaction interviews, as examples.
- **Quality Improvement and Outcomes Evaluation:** Full range participation in the systems CQI/TQM efforts.

During SFY 03/04, the Advocacy and Customer Services and the Community Policy Management sections of the Division will be developing direction, technical assistance and consultation to the field regarding opportunities for greater meaningful participation of consumers.

This document includes additional direction to the field regarding the local CFACs. This resulted from concerns that could be anticipated – the notion of consumer command is an evolving process. The Advocacy and Customer Services section will provide technical assistance and consultation to support the advancement of the local CFACs. In addition, this section will support the development of new grass roots community development of consumer advocacy groups.

State-Local Public Partnership

- **SFY 02/03 Outcome:** (1) Initiated a public policy relationship between the state and their local public partners.
- **SFY 03/04 Intended Outcome:** (1) Implement the public policy relationship between the state and their local public partners through the implementation of a formal venue for the development of the relationship, and (2) Provide a forum to discuss public policy issues.
- **SFY 04/05 Intended Outcome:** (1) Advance the public policy relationship between the state and their local public partners through on-going maturation of the relationship.

With the introduction of the *State Plan 2001: Blueprint for Change*, released in November 2001, a foundation for reform in North Carolina was created. With the publication of the State Plan 2002,

released in July 2002, three technical documents were included: the State Strategic Business Plan, the Local Business Plan and the Division's Reorganization Plan. These served as the platform from which the Division and area programs could begin the planning process to restructure through the development of strategic plans and Local Business Plans.

Within the Division's reorganization efforts, the Local Management Entity (LME) Systems Performance Team and other Teams were created and staffed to support the Division to meet the objectives set forth in the State Plan 2002: State Strategic Business Plan, Section III, and to support and assist all area programs with development and implementation of their local business plans. Staff was assigned to specific area programs to assist with efforts toward reform, regardless of the Phase selected for implementation. As staff who had previously been assigned to area programs began their new assignments these duties were transferred to members of the LME Systems Performance Team.

During SFY 02/03 there were formal county commissioner and county manager workshops held in regions across the state. Additionally, workshops and meetings were held with county commissioners, county managers, board members, area directors and stakeholders within specific programs. Communication Bulletin #005: Questions and Answers for County Commissioners/Managers was written as a direct result of questions raised at these meetings. By October 1, 2002 county authorities had submitted all letters of intent with choice of local governance, appointment of LME, and indication of phase-in preference.

Meetings were held in conjunction with the Council of Community Programs and the NC Association of County Commissioners for area program and county staff. Products were disseminated to assist area programs and counties in efforts to move forward. Two reports were disseminated by the Division to assist area programs in looking at prevalence, service need, penetration rates and Medicaid service billing.

During SFY 03/04 and evolving into the future, the Division will engage in a more formal public policy relationship with our county and LME partners. The public systems – state and county – are ultimately held accountable for the implantation and management of public policy.

Public-Private Partnership

Outlined in the foundation of reform is the role of consumers, families, advocates and providers. As we implement reform it is important that we promote and model public-private partnerships. This includes formalizing the process for meaningful input and review of stakeholders in a planned way. During SFY 02/03, the Division of MH/DD/SA formed an external stakeholder group to advise the Director regarding the implementation of reform. This group will be invited to continue serving in the role of the key stakeholder advisory group to provide guidance in the implementation of the reform efforts.

Within every local community, the relationship between the LME, the provider network and their community partners at large will be a vital component in successful implementation of reform.

LMEs are expected to cultivate partnerships among their community agencies such as law enforcement, juvenile justice, courts, social services, public school systems, community hospitals, and medical community in order to promote a comprehensive system of services and supports for people who have mh/dd/sa needs. As reviewed in the local business plan, concentrated efforts are needed to highlight the role of the LME with this community collaboration. Over the course of SFY 03/04, additional guidance will be provided regarding the desired outcome of successful partnerships.